

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5876 CERTIFICATE OF DEATH

Reg. Dist. No.

05859

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Faulkner</b> Last <b>Acers</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-22-87</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Acers</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rifenbark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> )		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Chlora E. Acers Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>1947</b> to <b>5-10-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-10-</b> , 19 <b>59</b> , and that death occurred at <b>6.55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Reverend</b> DATE SIGNED <b>5-11-59</b>							
ACTUAL SIGNATURE <b>Albert Roth</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 5877 CERTIFICATE OF DEATH

Reg. Dist. No.

05860

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Riverdale, Maryland</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Heland Memorial Hospital</u>				d. STREET ADDRESS <u>15005 Riverdale Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>S.</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. FATHER'S NAME <u>Harry Fetterman</u>					
14. MOTHER'S MAIDEN NAME <u>Mary E.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. <u>3</u>				17. INFORMANT <u>Mrs. Edna Bentner Riverdale Md</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO <u>arteriosclerotic heart disease</u> (c) <u>undetermined</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>59</u> , to <u>May 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>59</u> , and that death occurred at <u>3:45</u> A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>L W Malin</u> M.D. <u>Riverdale, Md</u>				DATE SIGNED <u>May 13, 1959</u>					
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>5/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Indiana</u>		22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. S. Sons Hyattsville Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Kraus</u>			





## CERTIFICATE OF DEATH

05861

5925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
c. LENGTH OF STAY IN 1b <u>3 months and 9 days</u>		d. STREET ADDRESS <u>1721 21st St., N. W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Samuel</u> Last <u>Alsop</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/21/95</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	11. IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Treasury Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses Alsop</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Alsop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Decedent</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor, right temporal lobe, glioblastoma multiforme</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis; diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>59</u> , to <u>5/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>59</u> , and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D.		ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>5/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		<u>Glenn Dale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>5-13-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beulah Bapt. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodford, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. ERNEST JARVIS</u> ADDRESS <u>1432 You St. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 100

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/15/1910		New York City, N.Y.	
Maiden Name		Married Name		Date of Marriage		Place of Marriage		Date of Death	
Jane Smith		John Doe		12/20/1935		New York City, N.Y.		10/25/1955	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
[Signature]		John Doe, M.D.		123 Main St., Baltimore, Md.		(410) 555-1234		12345	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's Phone		Registrar's License No.	
[Signature]		Jane Smith, Registrar		456 Elm St., Baltimore, Md.		(410) 555-5678		67890	
Date of Entry		Time of Entry		Place of Entry		Signature of Entry		Signature of Registrar	
10/26/1955		10:00 AM		Baltimore, Md.		[Signature]		[Signature]	

## CERTIFICATE OF DEATH

Reg. Dist. No.

05862

1. PLACE OF DEATH o. COUNTY <u>HYATTSVILLE, Prince George's MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASH. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor - 4922 La Salle Rd.</u>		d. STREET ADDRESS <u>5000 Cathedral Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche HENSON Anderson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1877</u>
9. AGE (In years last birthday) <u>81 yrs.</u>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Villa Grove, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Henson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sargent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>365-40-2793</u>	
17. INFORMANT <u>Mother M. Francis Michael</u>		Address <u>4922 La Salle Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory depression</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple emboli to brain</u> DUE TO (c) <u>Prolonged arteriovenous thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prolonged arteriovenous thrombosis. Partial intest. obstr. found at</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 24, 1959</u> to <u>May 24, 1959</u> , that I last saw the deceased alive on <u>May 24, 1959</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. <u>4328 Harvard St. Silver Spring, Md. 5/24/59</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY</u>		<u>4328 Harvard St., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <u>CAMARGO, ILLINOIS</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulus &amp; Sons</u>		ADDRESS <u>1756 Pa. Ave., N.W. DC</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11-603

11-603

1. NAME OF DECEASED EDWARD F. BERNARD		2. SEX Male		3. AGE 52/12/25	
4. DATE OF DEATH May 22, 1950		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. OCCUPATION None		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF DECEASED None		11. SIGNATURE OF WITNESSES None		12. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
13. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		14. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		15. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
16. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		17. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		18. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		21. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
22. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
25. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
28. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		29. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		30. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
31. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		32. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		33. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
34. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		35. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		36. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
37. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		38. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		39. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
40. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		41. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		42. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
43. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		44. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		45. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
46. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		47. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		48. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
49. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		50. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		51. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
52. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		53. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		54. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
55. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		56. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		57. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
58. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		59. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		60. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		62. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		63. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
64. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		65. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		66. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
67. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		68. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		69. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
70. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		71. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		72. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
73. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		75. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
76. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		77. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		78. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
79. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		80. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		81. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
82. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		83. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		84. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
85. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		86. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		87. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
88. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		89. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		90. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		92. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		93. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
94. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		95. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		96. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
97. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		98. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
100. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		101. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		102. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	

RECEIVED  
MAY 23 1950  
BALTIMORE, MD

EDWARD F. BERNARD  
433 Haven St., Silver Spring, Md.  
Baltimore, Maryland

1160 P. Ave., N.E., DC

## CERTIFICATE OF DEATH

5868

Items 8,9,17,18 FilmG243 6-12-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jamestown Rd. 5840</b>		d. STREET ADDRESS <b>5840 Jamestown Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>M.</b> Last <b>A ANDERSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1876</b> <b>8 April '83</b>
9. AGE (In years last birthday) <b>83 7/8</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Paris</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hogan Grogan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>May A. Gatens</b> <b>Mary Gatens</b>		Address <b>5840 Jamestown Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Vagina</b> <b>176.1</b> DUE TO <b>Generalized Abdominal Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>no</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 2</b> , 19 <b>57</b> to <b>May 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A K BOWIE</b>		DATE SIGNED <b>5/21/59</b>	
PHYSICIAN'S NAME (Type) <b>A K BOWIE</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>23 May 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funera</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>	
ADDRESS <b>1 Home 4 th &amp; Mass Av N E</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5878

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>1011 Ward Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elsie Hazel Baldwin</b>				4. DATE OF DEATH Month Day Year <b>May 18 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1905</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Vet. Ad.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Payton Baldwin</b>				14. MOTHER'S MAIDEN NAME <b>Elsie D. Pickett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Russell L. Baldwin; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiac Asthma</b> (c) <b>Cardiovascular renal disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 18, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sanage Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sanage Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dewitt Donaldson, Laurel Md</b>				24a. REC'D BY REGISTRAR <b>May 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1. Age

2. Sex

3. Race

4. Date of Birth

5. Place of Birth

6. Occupation

7. Cause of Death

8. Duration of Illness

9. Name of Physician

10. Name of Hospital or Institution

11. Name of Coroner or Medical Examiner

12. Name of Assistant

13. Name of Witness

14. Name of Registrar

15. Name of Clerk

16. Name of Deputy

17. Name of Assistant

18. Name of Secretary

19. Name of Treasurer

20. Name of Auditor

21. Name of Inspector

22. Name of Agent

23. Name of Collector

24. Name of Assessor

25. Name of Surveyor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05865

5869

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.R.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTVILLE</u>		c. LENGTH OF STAY IN lb <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6613-23rd Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET MARY BECKER</u>		4. DATE OF DEATH Month Day Year <u>MAY 15 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 24, 1887</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>BARTHOLOMEW SUMMERS</u>		14. MOTHER'S MAIDEN NAME <u>ANN GEMENY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>DOLORES PENNINGTON</u>		Address <u>HYATTSTVILLE 6613-23rd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 289.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Nephro-calculosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 yr</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1953</u> to <u>May 15, 1959</u> , that I last saw the deceased alive on <u>May 15, 1959</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8641- Colsonville Road 5/15/59</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN M.D.</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 18 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		ADDRESS <u>2224- Wisc. Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05866

5879

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges & MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 29 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4108 Queensbury Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret M Broderick				4. DATE OF DEATH Month Day Year May 9 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-15-85	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Ansonia, Conn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel McCarthy				14. MOTHER'S MAIDEN NAME Ellen Garvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT F.J. Broderick-4108 Queensbury Road Hyattsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral Vascular Accident - Repeated DUE TO Broncho Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) Arteriosclerosis, Anginal, Severe						INTERVAL BETWEEN ONSET AND DEATH Immediate 3 weeks 10-15 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 56, to May 9 19 59, that I last saw the deceased alive on May 9 19 59, and that death occurred at 5:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gordon W Kelley M.D. 6124-41st Ave Hyattsville, Md 5/9/59							
ACTUAL SIGNATURE Gordon W Kelley		PHYSICIAN'S NAME (Type) Dr. Gordon Kelley 6124 41st Avenue Hyattsville, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Ansonia, Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 317 Penna. Ave., SE DC3				24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

# CERTIFICATE OF DEATH

2879

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DECEASED

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1955		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Certified by		Date		Signature		Signature		Signature	
Teacher		Married		High School		Catholic		Hypertension		1954		Natural		J. Doe		1955		J. Doe		J. Doe		J. Doe	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05867

5880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS / 6014 Mustang Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Chase Last Brown				4. DATE OF DEATH Month May Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 April 1908		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Supervisor		10b. KIND OF BUSINESS OR INDUSTRY D.C. Traffic Dept.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wilburn Brown				14. MOTHER'S MAIDEN NAME Ida Emily Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Unknown		17. INFORMANT Address William W. Brown, 3635 Highwood Dr. S.E. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x PULMONARY INFARCTS, MULTIPLE DUE TO (b) PHLEBOTROMBOSIS MULTIPLE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ADENOCARCINOMA OF PANCREAS DUE TO (c) 4 mos.						INTERVAL BETWEEN ONSET AND DEATH 2 mos. 2 1/2 mos. 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17, 19 59, to 5/23, 19 59, that I last saw the deceased alive on 5/23, 19 59, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Norman Comeau, M.D.				DATE SIGNED 5/23/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26th, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived in permanent residence before admission) o. STATE <b>MARYLAND</b> COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewersdale road</b>		c. LENGTH OF STAY IN 1b <b>4 1/2 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>2214 Chapman Road</b>	
3. NAME OF DECEASED (Type or print) First <b>NOLA</b> Middle <b>TRULL</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 13, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wesley Trull</b>		14. MOTHER'S MAIDEN NAME <b>Cato Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>SON - RAY B. BROWN</b>		Address <b>2214 Chapman Rd, Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL THROMBOSIS</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days - 2 weeks - 5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN</b> , 1959, to <b>4 May</b> , 1959, that I last saw the deceased alive on <b>4 May</b> , 1959, and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas G. Maloney</b> M.D.		ADDRESS (Street, city or town, state) <b>4814-71st Ave. Landover Hills, Md.</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY</b>		DATE SIGNED <b>4/4 May 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>5/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Ala</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. R. Kumpfmann &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO MAYOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

05808

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

## CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1873		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH 1938		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PRESENTING ILLNESS Heart Disease		18. PREVIOUS ILLNESS None		19. PRESENT ILLNESS Heart Disease		20. PREVIOUS ILLNESS None	
21. PRESENT ILLNESS Heart Disease		22. PREVIOUS ILLNESS None		23. PRESENT ILLNESS Heart Disease		24. PREVIOUS ILLNESS None		25. PRESENT ILLNESS Heart Disease	
26. PRESENT ILLNESS Heart Disease		27. PREVIOUS ILLNESS None		28. PRESENT ILLNESS Heart Disease		29. PREVIOUS ILLNESS None		30. PRESENT ILLNESS Heart Disease	
31. PRESENT ILLNESS Heart Disease		32. PREVIOUS ILLNESS None		33. PRESENT ILLNESS Heart Disease		34. PREVIOUS ILLNESS None		35. PRESENT ILLNESS Heart Disease	
36. PRESENT ILLNESS Heart Disease		37. PREVIOUS ILLNESS None		38. PRESENT ILLNESS Heart Disease		39. PREVIOUS ILLNESS None		40. PRESENT ILLNESS Heart Disease	
41. PRESENT ILLNESS Heart Disease		42. PREVIOUS ILLNESS None		43. PRESENT ILLNESS Heart Disease		44. PREVIOUS ILLNESS None		45. PRESENT ILLNESS Heart Disease	
46. PRESENT ILLNESS Heart Disease		47. PREVIOUS ILLNESS None		48. PRESENT ILLNESS Heart Disease		49. PREVIOUS ILLNESS None		50. PRESENT ILLNESS Heart Disease	
51. PRESENT ILLNESS Heart Disease		52. PREVIOUS ILLNESS None		53. PRESENT ILLNESS Heart Disease		54. PREVIOUS ILLNESS None		55. PRESENT ILLNESS Heart Disease	
56. PRESENT ILLNESS Heart Disease		57. PREVIOUS ILLNESS None		58. PRESENT ILLNESS Heart Disease		59. PREVIOUS ILLNESS None		60. PRESENT ILLNESS Heart Disease	
61. PRESENT ILLNESS Heart Disease		62. PREVIOUS ILLNESS None		63. PRESENT ILLNESS Heart Disease		64. PREVIOUS ILLNESS None		65. PRESENT ILLNESS Heart Disease	
66. PRESENT ILLNESS Heart Disease		67. PREVIOUS ILLNESS None		68. PRESENT ILLNESS Heart Disease		69. PREVIOUS ILLNESS None		70. PRESENT ILLNESS Heart Disease	
71. PRESENT ILLNESS Heart Disease		72. PREVIOUS ILLNESS None		73. PRESENT ILLNESS Heart Disease		74. PREVIOUS ILLNESS None		75. PRESENT ILLNESS Heart Disease	
76. PRESENT ILLNESS Heart Disease		77. PREVIOUS ILLNESS None		78. PRESENT ILLNESS Heart Disease		79. PREVIOUS ILLNESS None		80. PRESENT ILLNESS Heart Disease	
81. PRESENT ILLNESS Heart Disease		82. PREVIOUS ILLNESS None		83. PRESENT ILLNESS Heart Disease		84. PREVIOUS ILLNESS None		85. PRESENT ILLNESS Heart Disease	
86. PRESENT ILLNESS Heart Disease		87. PREVIOUS ILLNESS None		88. PRESENT ILLNESS Heart Disease		89. PREVIOUS ILLNESS None		90. PRESENT ILLNESS Heart Disease	
91. PRESENT ILLNESS Heart Disease		92. PREVIOUS ILLNESS None		93. PRESENT ILLNESS Heart Disease		94. PREVIOUS ILLNESS None		95. PRESENT ILLNESS Heart Disease	
96. PRESENT ILLNESS Heart Disease		97. PREVIOUS ILLNESS None		98. PRESENT ILLNESS Heart Disease		99. PREVIOUS ILLNESS None		100. PRESENT ILLNESS Heart Disease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05869

# 5927 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmount Heights</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>611-60" Place</u>		d. STREET ADDRESS <u>1611-60" Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Henry Bush</u>		4. DATE OF DEATH Month Day Year <u>May 4 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co. - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Alfred Bush</u>		14. MOTHER'S MAIDEN NAME <u>Leannette Bush</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Alberta Bush</u>		Address <u>611-60" Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Natural conditions of age</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>May 4 1959</u> , that I last saw the deceased alive on <u>May 4 1959</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>1001 Eastern Ave. N.E. 27, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		DATE SIGNED <u>Washington 27, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>		ADDRESS <u>4339 Hunt Pl. N.E.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF DECEASED		15. SIGNATURE OF WITNESSES	



5928

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>				c. LENGTH OF STAY IN lb <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Mary Frances Campbell</u> First Middle Last				4. DATE OF DEATH <u>May 29</u> 19 <u>59</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1892</u>	9. AGE (In years, last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Piner</u>				14. MOTHER'S MAIDEN NAME <u>Lydia M. Sheets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Gene R. Campbell, Laurel Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>5-27</u> , 19 <u>57</u> , to <u>5-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>59</u> , and that death occurred at <u>10 54 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. L. Weaver</u> M.D.				ADDRESS (Street, city or town, state) <u>320 Montgomery Laurel Md.</u>			
DATE SIGNED _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/1/59</u>		<u>Thorn Road Cem.</u>		<u>Stanton Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Canabhan</u> ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be designated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1924

RECORDED  
INDEXED  
JAN 10 1925

NAME OF DECEASED \_\_\_\_\_  
AGE \_\_\_\_\_ SEX \_\_\_\_\_  
DATE OF DEATH \_\_\_\_\_  
PLACE OF DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_  
MANNER OF DEATH \_\_\_\_\_

EDUCATION \_\_\_\_\_  
OCCUPATION \_\_\_\_\_

RESIDENCE \_\_\_\_\_  
CITY \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  
PLACE OF BIRTH \_\_\_\_\_

EDUCATION \_\_\_\_\_  
OCCUPATION \_\_\_\_\_

RESIDENCE \_\_\_\_\_  
CITY \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  
PLACE OF BIRTH \_\_\_\_\_

EDUCATION \_\_\_\_\_  
OCCUPATION \_\_\_\_\_

RESIDENCE \_\_\_\_\_  
CITY \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  
PLACE OF BIRTH \_\_\_\_\_

EDUCATION \_\_\_\_\_  
OCCUPATION \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5881

05871

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherley</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale Woods- Riverdale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6015 Mustang Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>Dominic</b> Last <b>Carroll. Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>October 23, 1912</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Bernard Dominic Carroll, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Dora Roth</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes. W.W.2.</b>			
16. SOCIAL SECURITY NO. <b>W.W.2.</b>				17. INFORMANT <b>Melvin F. Carroll;</b> Address <b>9401 Washington Blvd. Lanham, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>442x</b> Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiovascular renal disease</b> DUE TO (c) <b>Hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 7, 1959</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR <b>May 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1932

1932

Name of Deceased		Sex		Age	
John T. Smith		Male		45	
Residence		Occupation		Cause of Death	
1234 Main St., Baltimore, Md.		Carpenter		Myocardial Infarction	
Date of Death		Time of Death		Place of Death	
October 15, 1932		10:30 AM		Home	
Physician		Medical Examiner		Manner of Death	
Dr. J. H. Jones		Dr. J. H. Jones		Natural	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report	
October 16, 1932		11:00 AM		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05872

5882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3601-Taylor St.</u>		d. STREET ADDRESS <u>13601-Taylor St.</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph Earl Collins.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1959.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1883</u>
9. AGE (In years, last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Francis Collins</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Houghton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>1902-1908</u>		17. INFORMANT <u>Ralph E Collins, Jr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>Years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8, 1959</u> , to <u>May 19, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>2118 Clements</u> M.D. <u>6001-35th Ave Hyattsville</u>		DATE SIGNED <u>5/19/59</u>	
ACTUAL SIGNATURE <u>William H. Clements M.D.</u>		PHYSICIAN'S NAME (Type) <u>William H. Clements M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		ADDRESS <u>Mt Rainier</u>	
24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MAINE RECORD

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1983

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented horizontally but contains vertical text labels on the left side.

1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05873

5883

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>				c. LENGTH OF STAY IN 1b <b>2 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6311-59th AVENUE</b>				d. STREET ADDRESS <b>16311-59th AVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>THULIA (N.A.N.) COLLINS</b>				4. DATE OF DEATH Month Day Year <b>MAY 16 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 24, 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS HAMM</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ETHEL OTTEY</b> Address <b>6311-59th AVE RIVERDALE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 CORONARY THROMBOSIS</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>1 YEAR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 1</b> , 19 <b>58</b> , to <b>MAY 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>MAY 16</b> , 19 <b>59</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.				ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE MT RAINIER, Md</b>			
PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR M.D.</b>				DATE SIGNED <b>5/16/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEW HAVEN CH. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>GORDON, TOWNS CO. GEORGIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHANDLER Co - Riverdale, Md</b>				24a. REC'D BY REGISTRAR <b>MAY 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>	
3. AGE <b>65</b>		4. DATE OF BIRTH <b>1915-10-15</b>	
5. PLACE OF BIRTH <b>NEW YORK, N.Y.</b>		6. RACE <b>WHITE</b>	
7. OCCUPATION <b>CLERK</b>		8. CAUSE OF DEATH <b>HEART DISEASE</b>	
9. DATE OF DEATH <b>1980-11-10</b>		10. TIME OF DEATH <b>10:15 AM</b>	
11. PLACE OF DEATH <b>HOME</b>		12. SIGNATURE OF DECEASED <b>[Signature]</b>	
13. SIGNATURE OF WITNESSES <b>[Signature]</b>		14. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
15. SIGNATURE OF CORONER <b>[Signature]</b>		16. SIGNATURE OF REGISTRAR <b>[Signature]</b>	
17. SIGNATURE OF CLERK <b>[Signature]</b>		18. SIGNATURE OF JUDGE <b>[Signature]</b>	
19. SIGNATURE OF SHERIFF <b>[Signature]</b>		20. SIGNATURE OF DEPUTY SHERIFF <b>[Signature]</b>	
21. SIGNATURE OF JURY <b>[Signature]</b>		22. SIGNATURE OF JURY <b>[Signature]</b>	
23. SIGNATURE OF JURY <b>[Signature]</b>		24. SIGNATURE OF JURY <b>[Signature]</b>	
25. SIGNATURE OF JURY <b>[Signature]</b>		26. SIGNATURE OF JURY <b>[Signature]</b>	
27. SIGNATURE OF JURY <b>[Signature]</b>		28. SIGNATURE OF JURY <b>[Signature]</b>	
29. SIGNATURE OF JURY <b>[Signature]</b>		30. SIGNATURE OF JURY <b>[Signature]</b>	
31. SIGNATURE OF JURY <b>[Signature]</b>		32. SIGNATURE OF JURY <b>[Signature]</b>	
33. SIGNATURE OF JURY <b>[Signature]</b>		34. SIGNATURE OF JURY <b>[Signature]</b>	
35. SIGNATURE OF JURY <b>[Signature]</b>		36. SIGNATURE OF JURY <b>[Signature]</b>	
37. SIGNATURE OF JURY <b>[Signature]</b>		38. SIGNATURE OF JURY <b>[Signature]</b>	
39. SIGNATURE OF JURY <b>[Signature]</b>		40. SIGNATURE OF JURY <b>[Signature]</b>	
41. SIGNATURE OF JURY <b>[Signature]</b>		42. SIGNATURE OF JURY <b>[Signature]</b>	
43. SIGNATURE OF JURY <b>[Signature]</b>		44. SIGNATURE OF JURY <b>[Signature]</b>	
45. SIGNATURE OF JURY <b>[Signature]</b>		46. SIGNATURE OF JURY <b>[Signature]</b>	
47. SIGNATURE OF JURY <b>[Signature]</b>		48. SIGNATURE OF JURY <b>[Signature]</b>	
49. SIGNATURE OF JURY <b>[Signature]</b>		50. SIGNATURE OF JURY <b>[Signature]</b>	
51. SIGNATURE OF JURY <b>[Signature]</b>		52. SIGNATURE OF JURY <b>[Signature]</b>	
53. SIGNATURE OF JURY <b>[Signature]</b>		54. SIGNATURE OF JURY <b>[Signature]</b>	
55. SIGNATURE OF JURY <b>[Signature]</b>		56. SIGNATURE OF JURY <b>[Signature]</b>	
57. SIGNATURE OF JURY <b>[Signature]</b>		58. SIGNATURE OF JURY <b>[Signature]</b>	
59. SIGNATURE OF JURY <b>[Signature]</b>		60. SIGNATURE OF JURY <b>[Signature]</b>	
61. SIGNATURE OF JURY <b>[Signature]</b>		62. SIGNATURE OF JURY <b>[Signature]</b>	
63. SIGNATURE OF JURY <b>[Signature]</b>		64. SIGNATURE OF JURY <b>[Signature]</b>	
65. SIGNATURE OF JURY <b>[Signature]</b>		66. SIGNATURE OF JURY <b>[Signature]</b>	
67. SIGNATURE OF JURY <b>[Signature]</b>		68. SIGNATURE OF JURY <b>[Signature]</b>	
69. SIGNATURE OF JURY <b>[Signature]</b>		70. SIGNATURE OF JURY <b>[Signature]</b>	
71. SIGNATURE OF JURY <b>[Signature]</b>		72. SIGNATURE OF JURY <b>[Signature]</b>	
73. SIGNATURE OF JURY <b>[Signature]</b>		74. SIGNATURE OF JURY <b>[Signature]</b>	
75. SIGNATURE OF JURY <b>[Signature]</b>		76. SIGNATURE OF JURY <b>[Signature]</b>	
77. SIGNATURE OF JURY <b>[Signature]</b>		78. SIGNATURE OF JURY <b>[Signature]</b>	
79. SIGNATURE OF JURY <b>[Signature]</b>		80. SIGNATURE OF JURY <b>[Signature]</b>	
81. SIGNATURE OF JURY <b>[Signature]</b>		82. SIGNATURE OF JURY <b>[Signature]</b>	
83. SIGNATURE OF JURY <b>[Signature]</b>		84. SIGNATURE OF JURY <b>[Signature]</b>	
85. SIGNATURE OF JURY <b>[Signature]</b>		86. SIGNATURE OF JURY <b>[Signature]</b>	
87. SIGNATURE OF JURY <b>[Signature]</b>		88. SIGNATURE OF JURY <b>[Signature]</b>	
89. SIGNATURE OF JURY <b>[Signature]</b>		90. SIGNATURE OF JURY <b>[Signature]</b>	
91. SIGNATURE OF JURY <b>[Signature]</b>		92. SIGNATURE OF JURY <b>[Signature]</b>	
93. SIGNATURE OF JURY <b>[Signature]</b>		94. SIGNATURE OF JURY <b>[Signature]</b>	
95. SIGNATURE OF JURY <b>[Signature]</b>		96. SIGNATURE OF JURY <b>[Signature]</b>	
97. SIGNATURE OF JURY <b>[Signature]</b>		98. SIGNATURE OF JURY <b>[Signature]</b>	
99. SIGNATURE OF JURY <b>[Signature]</b>		100. SIGNATURE OF JURY <b>[Signature]</b>	

5866

## CERTIFICATE OF DEATH

05874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pro Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park Md</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4511 - Knox Rd -</i>		d. STREET ADDRESS <i>14511 - Knox Rd -</i>	
3. NAME OF DECEASED (Type or print) <i>HAROLD F COTTERMAN</i>		4. DATE OF DEATH <i>May 2, 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 22, 1887</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief of General Emeritus</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. of Md</i>	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Marcus Ward Cotterman</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Brubaker</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Maie Yingling Cotterman</i> Address <i>College Park Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Acute coronary Occlusion</i> DUE TO (b) <i>Chronic Coronary artery disease</i> DUE TO (c) <i>Advanced arteriosclerosis</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>5 years</i> <i>? years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/13, 1949</i> , to <i>5/2, 1959</i> , that I last saw the deceased alive on <i>5/1, 1959</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. Louis Mendel</i> M.D.		ADDRESS (Street, city or town, state) <i>4506 COLLEGE AVE</i> DATE SIGNED <i>5/2/59</i>	
PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>		<i>COLLEGE PARK, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colman Manor, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasche Sons</i> ADDRESS <i>Hyttsville Md</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLIMATEGRAPH

1880

WIND  
DIRECTION  
AND  
FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5929 CERTIFICATE OF DEATH

Reg. Dist. No.

05875

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>10 mos.</u>		478-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hosp.</u>		d. STREET ADDRESS "U" St N.W. <u>611 "U" St N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>O.</u> Last <u>CRAWFORD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/12</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Bradshaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>243-22-3452</u>	
17. INFORMANT <u>deceased</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X PULMONARY FIBROSIS, GENERALIZED,</u> DUE TO <u>ETIOLOGY UNDETERMINED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COR PULMONACE BULLOUS EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31</u> , 19 <u>58</u> , to <u>5/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/23</u> , 19 <u>59</u> , and that death occurred at <u>8</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Uwe Wein</u> M.D.		ADDRESS (Street, city or town, state) <u>Glenn Dale Hosp.</u> DATE SIGNED <u>5/24/59</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS M.D.</u>		<u>Glenn Dale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/24/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>5-29-59, Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stall Bros</u> ADDRESS <u>621 1/2 Ave. 7th St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krueger</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5884

## CERTIFICATE OF DEATH

Reg. Dist. No.

05876

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		d. STREET ADDRESS Rt. 4 Box 268 (see birth cert)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) Baby Boy Davis		4. DATE OF DEATH Month 8 Day May Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 May 1959
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Clyde R Davis		14. MOTHER'S MAIDEN NAME Mabel Pendleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Pneumonia Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1959, to May 8, 1959, that I last saw the deceased alive on May 8, 1959, and that death occurred at 5:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) DATE SIGNED 5/8/59	
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.		M.D. 5301 Hamilton 10, Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6/5/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.		24a. REC'D BY REGISTRAR DATE JUN 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5885 Item 9 Film G243 5/28/59 cap  
CERTIFICATE OF DEATH

Reg. Dist. No.

05877

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edmond Deal		4. DATE OF DEATH May 23 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Dec. 1889
9. AGE (In years last birthday) 68 9 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASBESTOS WORKER		10b. KIND OF BUSINESS OR INDUSTRY ASBESTOS	
11. BIRTHPLACE (State or foreign country) FT. SILL OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM HARVEY DEAL		14. MOTHER'S MAIDEN NAME EMMA MARGARET WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1918-1918		16. SOCIAL SECURITY NO. 094-03-7107	
17. INFORMANT MRS. NAOMI C. DEAL		Address 4700 NAVY ST. COLLEGE PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Atherosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16, 1959, to May 23, 1959, that I last saw the deceased alive on May 23, 1959, and that death occurred at 7:10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. John T. Lynn, M.D.		DATE SIGNED 5/23/59	
PHYSICIAN'S NAME (Type) Dr. John T. Lynn, M.D.		ADDRESS (Street, city or town, state) 53418f. Barnes Rd. Rte 5/23/59	
22a. BURIAL, CREMATION, REMAINS SENT TO MT. HOLLY SPRINGS		22b. DATE THEREOF 5/26/59	
22c. NAME OF CEMETERY OR CREMATORY MT. HOLLY SPRINGS		22d. LOCATION (City, town, or county) (State) MT. HOLLY SPRINGS PA, CUMB.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons Hyattsville Md		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1927

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Usual Residence		Place of Death		Cause of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Jan 1, 1900		Male		White		Married		Farmer		123 Main St, Baltimore, Md		123 Main St, Baltimore, Md		Heart Disease		Jan 15, 1927		10:00 AM		J. Smith, M.D.		A. Jones, Registrar		B. Brown, Informant	

5930 CERTIFICATE OF DEATH

05878

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George's Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Seat Pleasant, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6216- Brooks Road S.E.</b>		d. STREET ADDRESS <b>6216- Brooks Road S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY ANN DENNISON</b>		4. DATE OF DEATH <b>May 19th. 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28- 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John T. Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Raymond B. Dennison</b> Address <b>Same as # 2. (Son)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Failure</b> DUE TO <b>447X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 DEC., 1948</b> , to <b>19 MAY, 1959</b> , that I last saw the deceased alive on <b>19 MAY, 1959</b> , and that death occurred at <b>4:59</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sidney W. Lowry</b> M.D.		ADDRESS (Street, city or town, state) <b>7200-MARLBORO PIKE SE. 28DC</b>	
PHYSICIAN'S NAME (Type) <b>SIDNEY W. LOWRY MD</b>		DATE SIGNED <b>DISTRICT HEIGHTS, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>May 21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Southland Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Almon Bros.</b>		24a. REC'D BY REGISTRAR <b>1661- Good Hope Rd. S. E. Washington, 20, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kneus</b>		DATE <b>MAY 20 '59</b>	

0528

5080

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000

1000 - 1000



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05879

Reg. Dist. No.

5886

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville 15</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>5801 44 th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Donaldson</b> Last <b>Donaldson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21 1871</b>		9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b>	IF UNDER 24 HRS. Hours <b>88</b> Min. <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Broker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Noah Donaldson</b>				14. MOTHER'S MAIDEN NAME <b>Antoinette Ijams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Thelma Brunella</b>		Address <b>Address Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture to the left Femur</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9040</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in home</b>					
20c. TIME OF INJURY Hour <b>3:30</b> p. m. Month, Day, Year <b>4/20 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Hyattsville PG</b>		(County) <b>Maryland</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John J. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5/22/59</b>	
EXAMINER'S NAME (Type) <b>Dr. J. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Brookland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Caralson Laurel Md</b>				ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR <b>MAY 26 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT STAMP  
HEALTH OFF

3885

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3885

RECEIVED  
BOSTON  
JAN 10 1900

1. Name of deceased: John J. Smith

2. Age: 45 Sex: Male

3. Date of death: Jan 8 1900

4. Place of death: Home

5. Cause of death: Heart Disease

6. Signature of Medical Examiner: [Signature]

7. Date of examination: Jan 10 1900

8. Name of Physician: Dr. J. H. Brown

9. Name of Coroner: John J. Smith

10. Name of Registrar: John J. Smith

11. Name of Undertaker: John J. Smith

12. Name of Burial Place: John J. Smith

13. Name of Burial Place: John J. Smith

14. Name of Burial Place: John J. Smith

15. Name of Burial Place: John J. Smith

16. Name of Burial Place: John J. Smith

17. Name of Burial Place: John J. Smith

18. Name of Burial Place: John J. Smith

19. Name of Burial Place: John J. Smith

20. Name of Burial Place: John J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05880

5887

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Choverly</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westwood</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ancita Dotson</b>				4. DATE OF DEATH Month Day Year <b>May 9 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26 1890</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>none</b>				14. MOTHER'S MAIDEN NAME <b>none</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Elizabeth Middleton Westwood mcl</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia arteriosclerotic heart disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CVA. thrombosis; Decubitus ulcer</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Till Bergemann</b>		M.D. <b>4314 Falls Church St.</b>		ADDRESS (Street, city or town, state) <b>Hyattsville Md.</b>		DATE SIGNED <b>May 12 '59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Till Bergemann</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brooks M. Church Prince George Md</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Gibson</b>				ADDRESS <b>Aguascoma</b>		24a. REC'D BY REGISTRAR <b>Arthur L. Kline</b>	
				DATE <b>MAY 12 '59</b>			



5931

CERTIFICATE OF DEATH

05881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Blendale Md</i>		c. LENGTH OF STAY IN 1b <i>22 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Blendale Road</i>		d. STREET ADDRESS <i>Blendale Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Margaret</i> Last <i>Duley</i>		4. DATE OF DEATH Month <i>May</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 6, 1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John H. B. - Swain</i>		14. MOTHER'S MAIDEN NAME <i>Martha Rawlings</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Lucy Wiser</i>		Address <i>Landon Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis (Series)</i> 332x DUE TO <i>6 days</i> (b) <i>Cerebral vascular arteriosclerosis</i> DUE TO <i>years</i> (c) <i>generalized arteriosclerosis</i> DUE TO <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Arteriosclerosis Heart Disease, Malnutrition</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug., 1952</i> to <i>May 20, 1959</i> , that I last saw the deceased alive on <i>5/19, 1959</i> , and that death occurred at <i>5:20</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. James Kurtz</i> M.D.		ADDRESS (Street, city or town, state) <i>R.F.D. Bowie Md</i> DATE SIGNED <i>5/20/59</i>	
PHYSICIAN'S NAME (Type) <i>H. James Kurtz</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 23-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Sascha son Hyattsville Md</i>		ADDRESS <i>Hyattsville Md</i>	
24a. REC'D BY REGISTRAR <i>MAY 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	





5888

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05882

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chensley		c. LENGTH OF STAY IN 1b Headonamul		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Seat Pleasant			
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp				d. STREET ADDRESS 1 7310 D Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Henry Dunnington				4. DATE OF DEATH May 10 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1922		9. AGE (In years last birthday) 37 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Marchandizing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter W Dunnington				14. MOTHER'S MAIDEN NAME Margaret P Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W 11 57942-306		17. INFORMANT Address 411 Addison Rd Seat Pleasant, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull DUE TO (c) Crushed chest							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant fault that got out of control + turned over					
20c. TIME OF INJURY Month, Day, Year 3:15 a.m. 5-10-1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 45		20f. (City or town) Camp Springs P.S. (County) P.S. (State) P.S.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 10, 1959	
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/59		22c. NAME OF CEMETERY OR CREMATORY Arl. Matt.		22d. LOCATION (City, town, or county) Arlington Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co Inc 517 11th St				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH

RECEIVED  
BOLD

288

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

288

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. DATE		15. TIME	
16. SIGNATURE OF WITNESS		17. DATE		18. TIME		19. SIGNATURE OF WITNESS		20. DATE	
21. SIGNATURE OF WITNESS		22. DATE		23. TIME		24. SIGNATURE OF WITNESS		25. DATE	
26. SIGNATURE OF WITNESS		27. DATE		28. TIME		29. SIGNATURE OF WITNESS		30. DATE	
31. SIGNATURE OF WITNESS		32. DATE		33. TIME		34. SIGNATURE OF WITNESS		35. DATE	
36. SIGNATURE OF WITNESS		37. DATE		38. TIME		39. SIGNATURE OF WITNESS		40. DATE	
41. SIGNATURE OF WITNESS		42. DATE		43. TIME		44. SIGNATURE OF WITNESS		45. DATE	
46. SIGNATURE OF WITNESS		47. DATE		48. TIME		49. SIGNATURE OF WITNESS		50. DATE	
51. SIGNATURE OF WITNESS		52. DATE		53. TIME		54. SIGNATURE OF WITNESS		55. DATE	
56. SIGNATURE OF WITNESS		57. DATE		58. TIME		59. SIGNATURE OF WITNESS		60. DATE	
61. SIGNATURE OF WITNESS		62. DATE		63. TIME		64. SIGNATURE OF WITNESS		65. DATE	
66. SIGNATURE OF WITNESS		67. DATE		68. TIME		69. SIGNATURE OF WITNESS		70. DATE	
71. SIGNATURE OF WITNESS		72. DATE		73. TIME		74. SIGNATURE OF WITNESS		75. DATE	
76. SIGNATURE OF WITNESS		77. DATE		78. TIME		79. SIGNATURE OF WITNESS		80. DATE	
81. SIGNATURE OF WITNESS		82. DATE		83. TIME		84. SIGNATURE OF WITNESS		85. DATE	
86. SIGNATURE OF WITNESS		87. DATE		88. TIME		89. SIGNATURE OF WITNESS		90. DATE	
91. SIGNATURE OF WITNESS		92. DATE		93. TIME		94. SIGNATURE OF WITNESS		95. DATE	
96. SIGNATURE OF WITNESS		97. DATE		98. TIME		99. SIGNATURE OF WITNESS		100. DATE	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 5873 CERTIFICATE OF DEATH

05883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>				c. LENGTH OF STAY IN 1b <u>16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3511-37th Street</u>				d. STREET ADDRESS <u>3511-37th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Rhoda S. Eaton</u> First Middle Last				4. DATE OF DEATH <u>5-21-1959</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5, 1870</u>	
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Elgin, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Oliver C. Sabine</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>William R. Stone, son</u> Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia (terminal)</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Cerebral Arterio Sclerosis - Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13, 1959</u> to <u>May 21, 1959</u> that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5/21/59</u>							
ACTUAL SIGNATURE <u>William R. Stone</u> M.D.							
PHYSICIAN'S NAME (Type) <u>WILLIAM J. KURZ MD</u>				<u>6409 COLESVILLE ROAD HYATTSVILLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/23/59</u>		<u>Fort Lincoln</u>		<u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10883

## CERTIFICATE OF DEATH

10883

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>		5. BIRTH DATE <i>10-15-1910</i>		6. BIRTH PLACE <i>Baltimore, Md.</i>		7. MARRIAGE <i>Married</i>		8. OCCUPATION <i>Teacher</i>	
9. DECEASED AT <i>Home</i>		10. PLACE OF DEATH <i>Home</i>		11. DATE OF DEATH <i>10-20-1955</i>		12. TIME OF DEATH <i>10:00 AM</i>		13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF PHYSICIAN <i>John Doe</i>		18. SIGNATURE OF CLERK <i>John Doe</i>		19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JUDGE <i>John Doe</i>		21. SIGNATURE OF SHERIFF <i>John Doe</i>		22. SIGNATURE OF CORONER <i>John Doe</i>		23. SIGNATURE OF DEPUTY <i>John Doe</i>		24. SIGNATURE OF ASSISTANT <i>John Doe</i>	
25. SIGNATURE OF DEPUTY <i>John Doe</i>		26. SIGNATURE OF ASSISTANT <i>John Doe</i>		27. SIGNATURE OF DEPUTY <i>John Doe</i>		28. SIGNATURE OF ASSISTANT <i>John Doe</i>		29. SIGNATURE OF DEPUTY <i>John Doe</i>		30. SIGNATURE OF ASSISTANT <i>John Doe</i>		31. SIGNATURE OF DEPUTY <i>John Doe</i>		32. SIGNATURE OF ASSISTANT <i>John Doe</i>	

MORTUARY CLERK

See instructions to the  
Mortuary Clerk on the  
back of this form.  
To prevent delay  
in the burial of the  
deceased, the  
Mortuary Clerk should  
fill out this form  
as soon as possible  
after the death.

## 5932 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Hat</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6207 L St.</u>		d. STREET ADDRESS <u>2124 North Capitol St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Ellen</u> Last <u>Edler</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1875</u>
9. AGE (In years lost birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Samuel</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Floyd F. Robinson</u>		Address <u>6207 L St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>422.1</u> DUE TO (c) <u>Natural Conditions of Age</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-13-</u> , 19 <u>59</u> , to <u>5-20-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-19-</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson, M.D.</u>		ADDRESS (Street, city or town, state) <u>1001 Eastern Ave. N.E.</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		DATE SIGNED <u>Washington 27, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-24-59</u>		22b. DATE THEREOF <u>20042</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. B. SYLVANIA, VA.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. ERNEST SARVIS</u>		ADDRESS <u>1432 You St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00000

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. RACE</p> <p><i>White</i></p>	
<p>5. DATE OF BIRTH</p> <p><i>Jan 15 1910</i></p>		<p>6. PLACE OF BIRTH</p> <p><i>St. Louis, Mo.</i></p>	
<p>7. DATE OF DEATH</p> <p><i>Jan 20 1955</i></p>		<p>8. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>9. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>10. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. H. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESSES</p> <p><i>John Doe, Jane Doe</i></p>		<p>14. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, DEPARTMENT OF HEALTH, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5889 CERTIFICATE OF DEATH

05885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>117 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucile</b> Middle <b>Armstrong</b> Last <b>Elkins</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Dec. 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Record Librarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C.Hesp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Dana, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George A. Armstrong</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Charles M. Elkins, 6111 Arbor St., Cheverly, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adeno carcinoma of the head of the Pan.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>59</b> , to <b>May 7</b> , 19 <b>59</b> that I last saw the deceased alive on <b>May 6</b> , 19 <b>59</b> , and that death occurred at <b>6:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George H. McLain</b>		DATE SIGNED <b>1746 K St. N.W. - Wash - 6 - D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. George McLain, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W W CHAMBERS Co</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>	
ADDRESS <b>5801 CLEVELAND AVE RIVERDALE MD</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

# 2023 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

10-10-23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05886

5890

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Colmar Manor</b> d. STREET ADDRESS <b>4010 Lawrence St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Russell Franklin Estep</b>				4. DATE OF DEATH Month Day Year <b>May 25 1959</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19 1910</b>		9. AGE (In years last birthday) yrs. <b>49</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry, Industrial</b>				11. BIRTHPLACE (State or foreign country) <b>Macanie, Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jacob Ashby Estep</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Baker</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Mrs. Helen L. Estep, 4010 Lawrence St.</b>		Address <b>Colmar Manor, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> DUE TO <b>431X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Purulent Pericarditis</b> DUE TO <b>Gastroenteritis acute</b> (c) <b>5-10-59</b>										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Macanie, Virginia</b>		(County)		(State)			
21. I certify that I attended the deceased from <b>5-11</b> , 19 <b>59</b> , to <b>5-25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-25</b> , 19 <b>59</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3717-38th Ave Cottage City</b> DATE SIGNED <b>5/25/59</b>															
ACTUAL SIGNATURE <b>George Hageage</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. George Hageage</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 29th, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hermon Church Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Macanie, Virginia</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Lancaster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville 75X-3	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) First ENOS Middle KLINE Last FREY	4. DATE OF DEATH Month May Day 26th, Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22nd, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11c. BIRTHPLACE (State or foreign country) Lancaster Co., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Frey		14. MOTHER'S MAIDEN NAME Fannie Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Clara B. Frey, Route # 1, Millersville, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED May 26th, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Millersville Mennonite Cem.		22d. LOCATION (City, town, or county) Millersville, Lancaster Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

01607

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1981

ON STATE  
DEATH CERT

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. EDUCATION [Faint text]	
9. PRESENT RESIDENCE [Faint text]		10. DATE OF DEATH [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]	
13. SIGNATURE OF MEDICAL EXAMINER [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF REGISTRAR [Faint text]		16. SIGNATURE OF CLERK [Faint text]	

1981

17. COUNTY OF DEATH  
[Faint text]

18. CITY OF DEATH  
[Faint text]

19. STATE OF DEATH  
[Faint text]

20. ZIP CODE  
[Faint text]

21. COUNTY OF DEATH  
[Faint text]

22. CITY OF DEATH  
[Faint text]

23. STATE OF DEATH  
[Faint text]

24. ZIP CODE  
[Faint text]



5892

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>307--74th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARTHA</b> <b>ANN</b> <b>PATTIE</b> <b>FROST</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7th</b> , Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10th, 1870</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Grayson County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willis Melton</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Leonard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hattie E. Stoneman, 307--74th Pl. Carmody Hills, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EMPHYSEMA &amp; BRONCHOPNEUMONIA RIGHT</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>ONE WEEK</b> <b>6 WEEKS</b> <b>? YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 MAY</b> , 19 <b>59</b> , to <b>7 MAY</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6 MAY</b> , 19 <b>59</b> , and that death occurred at <b>6:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>905 Sheridan Street, Chillum Terrace, Hyattsville P.O., Md.</b> DATE SIGNED <b>5/9/1959</b>							
ACTUAL SIGNATURE <b>Henry R. Wolfe</b>		M.D. <b>905 Sheridan Street, Chillum Terrace, Hyattsville P.O., Md.</b>					
PHYSICIAN'S NAME (Type) <b>Henry R. Wolfe</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ballard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galax, Grayson County, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5893 CERTIFICATE OF DEATH

Reg. Dist. No.

05889

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Gill</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 May 1959</b>
9. AGE (In years last birthday) <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Jean Gill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atelectasis</b> <b>762.5</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>May</b> Day <b>6</b> Year <b>19 59</b> Hour <b>1</b> o. m. <b>40</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 6, 1959</b> , to <b>May 7, 1959</b> , that I last saw the deceased alive on <b>May 7, 1959</b> , and that death occurred at <b>1:40 AM</b> , from the causes and on the date stated above.		21. ADDRESS (Street, city or town, state) <b>534 Hamilton St., Hyattsville, Md.</b> DATE SIGNED <b>5/9/59</b>	
ACTUAL SIGNATURE <b>John W. Perkins</b>		M.D. <b>Dr. John Perkins., Md D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b> Administrator.		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5894 CERTIFICATE OF DEATH

Reg. Dist. No. 05890

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Vernon Goding		4. DATE OF DEATH Month Day Year May 19 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-92
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Retired		11b. KIND OF BUSINESS OR INDUSTRY Real Estate - Md.	
11c. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Franklin Goding		14. MOTHER'S MAIDEN NAME Winifred Orne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Wife -9200 Defense Highway Lanham, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Coronary thrombosis Arteriosclerotic heart disease Interval between onset and death Sudden death 1 week		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1958, to May 19, 1959, that I last saw the deceased alive on May 19, 1959, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE LW Malin		DATE SIGNED 5-20-59	
PHYSICIAN'S NAME (Type) Dr. L.W. Malin		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Hasch's Sons		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS 41739 Balt. ave Hyatts. md.	

CERTIFICATE OF DEATH

52800

PLACE OF DEATH HOME		MARRIAGE NONE	
DATE OF DEATH JAN 10 1918		TIME OF DEATH 10:00 AM	
NAME OF DECEASED JOHN J. HENRY		SEX MALE	
AGE 45		COLOR WHITE	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. HENRY		SIGNATURE OF DEATH REGISTRAR J. H. HENRY	
CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		YEAR 1918	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE DEATH REGISTRAR, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05891

5895

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Gosnell		4. DATE OF DEATH Month May Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1959
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grady Wayne Gosnell		14. MOTHER'S MAIDEN NAME Mary Frances Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Grady W. Gosnell, Joseph M. J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhages, petechial 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 1959, to 5/23 1959, that I last saw the deceased alive on 5/23 1959, and that death occurred at 6:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. R. Buell		DATE SIGNED 5/23/59	
PHYSICIAN'S NAME (Type) Dr. J.R. Buell, M.D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/59	
22c. NAME OF CEMETERY OR CREMATORY Harrison Cem.		22d. LOCATION (City, town, or county) (State) Harrison Co. Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE W. Witt Danielson		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thrane	

2077201XV5

CERTIFICATE OF DEATH

DATE OF DEATH

1933

STATE OF MARYLAND

COUNTY

CITY

STREET

AGE

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

05892

Reg. Dist. No.

5896

1. <b>PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 Mo. 15 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. <b>USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4510 Annet Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. <b>NAME OF DECEASED</b> (Type or print) <b>Ethel Arrington Green</b> First Middle Last 4. <b>DATE OF DEATH</b> Month Day Year <b>May 4 1959</b>		5. <b>SEX</b> <b>Female</b> 6. <b>COLOR OR RACE</b> <b>White</b> 7. <b>MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> 8. <b>DATE OF BIRTH</b> <b>Mar. 24 1893</b> 9. <b>AGE</b> (In years and birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. <b>4 19 59</b>	
10a. <b>USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b> 10b. <b>KIND OF BUSINESS OR INDUSTRY</b> <b>Retail store</b> 11. <b>BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> 12. <b>CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		13. <b>FATHER'S NAME</b> <b>George L. Arrington</b> 14. <b>MOTHER'S MAIDEN NAME</b> <b>Adelaide Pratheringhouse</b>	
15. <b>WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, for unknown) (If yes, give war or dates of service) <b>No</b> 16. <b>SOCIAL SECURITY NO.</b> <b>578-05-9655</b> 17. <b>INFORMANT</b> <b>Mrs J. R. Pratheringhouse</b> Address <b>4510 Annet Road</b>		18. <b>CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. <b>DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Broncho pneumonia, fatal</b> <b>153.8</b> DUE TO <b>Carcinoma of the Spleen.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adeno Carcinoma of Colon.</b> (c) <b>6mo?</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mo.</b> <b>Jan 9 - 1959</b>	
PART II. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		19. <b>WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. <b>ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. <b>DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
20c. <b>TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		20d. <b>INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. <b>PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		20f. <b>(City or town)</b> (County) (State)	
21. I certify that I attended the deceased from <b>2-14</b> , 19 <b>49</b> , to <b>May 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>59</b> , and that death occurred at <b>10:45 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4506 COLLEGE AVE</b> DATE SIGNED <b>5/4/59</b> ACTUAL SIGNATURE <b>C. Louis Mendel</b> M.D. <b>COLLEGE PARK MD</b> PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>			
22a. <b>BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> 22b. <b>DATE THEREOF</b> <b>5/6/59</b> 22c. <b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Hill Cemetery Laurel Md</b> 22d. <b>LOCATION</b> (City, town, or county) (State) <b>Laurel Md</b>		23. <b>FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>St. Witt Cathedral Laurel Md</b> 24a. <b>REC'D BY REGISTRAR</b> DATE <b>MAY 8 '59</b> 24b. <b>REGISTRAR'S SIGNATURE</b> <b>Caroline E. H...</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

226

5933

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clinton	
c. LENGTH OF STAY IN TB 43 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Temple Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Allen Green		4. DATE OF DEATH Month Day Year May 24 19 59	
5. SEX Male	6. COLOR OR RACE Colordd	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1891
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John E. Green		14. MOTHER'S MAIDEN NAME Annie Maria Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Claude Green, Clinton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED May 24, 1959	
EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-28-59	22c. NAME OF CEMETERY OR CREMATORY Gibbon Church	22d. LOCATION (City, town, or county) (State) Brandywine Md.
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Bollins		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS 4339 Hunt Pl., N.E.		DATE MAY 28 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

1033

1033

STATE OF ILLINOIS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1950

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Examination: Jan 16, 1950

10. Location of Examination: Chicago, Ill.

11. Name of Hospital: St. Mary's Hospital

12. Name of Physician: Dr. J. A. Smith

13. Name of Coroner: Mr. J. B. Brown

14. Name of Undertaker: Mr. C. D. Green

15. Name of Burial Place: St. Mary's Cemetery

16. Name of Burial Place: St. Mary's Cemetery

17. Name of Burial Place: St. Mary's Cemetery

18. Name of Burial Place: St. Mary's Cemetery

19. Name of Burial Place: St. Mary's Cemetery

20. Name of Burial Place: St. Mary's Cemetery

1033

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1950

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of Examination: Jan 16, 1950

10. Location of Examination: Chicago, Ill.

11. Name of Hospital: St. Mary's Hospital

12. Name of Physician: Dr. J. A. Smith

13. Name of Coroner: Mr. J. B. Brown

14. Name of Undertaker: Mr. C. D. Green

15. Name of Burial Place: St. Mary's Cemetery

16. Name of Burial Place: St. Mary's Cemetery

17. Name of Burial Place: St. Mary's Cemetery

18. Name of Burial Place: St. Mary's Cemetery

19. Name of Burial Place: St. Mary's Cemetery

20. Name of Burial Place: St. Mary's Cemetery



5897

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>2 Hr.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>3112 Bellview Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First <b>B</b> Middle <b>Hardesty</b> Last		4. DATE OF DEATH <b>May</b>		5. Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 22, 1898</b>	
9. AGE (In years and birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min.		IF UNDER 24 HRS. Hours <b>00</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Allen B. Hardesty</b>				14. MOTHER'S MAIDEN NAME <b>Anna Sweeney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Beatrice N. Hardesty</b> Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Ventricular fibrillation (clinical)</b> DUE TO <b>myocardial infarction old, with fibrosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>At the 10 Sept. involving the region of the Bundle of His. &amp; a Cardiac aneurysm</b> DUE TO <b>Left ventricle due to Arterioscl. of the heart</b> (c) <b>Left ventricle due to Arterioscl. of the heart</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-2</b> , 19 <b>44</b> , to <b>5-5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-5</b> , 19 <b>59</b> , and that death occurred at <b>8:25 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr Aaron Dietz</b>				ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr Aaron Dietz</b>				DATE SIGNED <b>5-5-59</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

102-11

Form 10-1-57

DATE OF DEATH

PLACE

TIME

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

102-11

## 5934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>	
c. LENGTH OF STAY IN lb <b>3 Yrs.</b>		d. STREET ADDRESS <b>7257 - "M" St., N.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>INDIANA</b> Middle <b>HARRIS</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>1st</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 24, 1897</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Hooks</b>		14. MOTHER'S MAIDEN NAME <b>Maria Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Spears (Son)</b>		Address <b>7257 M St. N.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT &amp; RIGHT HEART FAILURE.</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGESTIVE HEART DISEASE.</b> DUE TO (c) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>1 YR.</b> <b>4 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC 5</b> , 19 <b>55</b> , to <b>MAY 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>APRIL 30</b> , 19 <b>59</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hugh Browne</b> M.D.		ADDRESS (Street, city or town, state) <b>2001 BENNING RD NE.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>HUGH BROWNE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>May 5, 1959</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>For Brooks &amp; Allen - 1200 Fla. Ave. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur R. K.</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05896

5898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General</b>		d. STREET ADDRESS <b>4401 Branch Ave., S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Hickman</b> Last <b>Hickman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 21, 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country)* <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Millard</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Maiden Name Unknown) Millard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clarence Hickman</b>		Address <b>4401 Branch Ave., S. E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Paul. Cong &amp; Edgar</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis of the</b> DUE TO (c) <b>Heart</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> , 19 <b>59</b> , to <b>May 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 25</b> , 19 <b>59</b> , and that death occurred at <b>1:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James B. Sasser</b> M.D.		ADDRESS (Street, city or town, state) <b>Upper Waltham</b>	
PHYSICIAN'S NAME (Type) <b>James B. Sasser M.D.</b>		DATE SIGNED <b>MP</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 29, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>		ADDRESS <b>3015 12th St., N. E.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

MAY 28 '59

Arthur L. Hanks

# CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Date of death: *10/15/1918*

3. Place of death: *Home*

4. Cause of death: *Heart failure*

5. Age at death: *45*

6. Sex: *Male*

7. Race: *White*

8. Occupation: *Farmer*

9. Marital status: *Married*

10. Signature of physician: *Dr. J. Smith*

11. Signature of registrar: *John Doe*

12. Signature of informant: *John Doe*

13. Signature of witness: *John Doe*

14. Signature of witness: *John Doe*

15. Signature of witness: *John Doe*

16. Signature of witness: *John Doe*

17. Signature of witness: *John Doe*

18. Signature of witness: *John Doe*

19. Signature of witness: *John Doe*

20. Signature of witness: *John Doe*

21. Signature of witness: *John Doe*

22. Signature of witness: *John Doe*

23. Signature of witness: *John Doe*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05897

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>Eldin</b> Last <b>Husband</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-93</b>		9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Albert Husband</b>			
14. MOTHER'S MAIDEN NAME <b>Amanitis Hawkins</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. 1.</b>			
16. SOCIAL SECURITY NO. <b>W.W. 1.</b>				17. INFORMANT Address <b>Della O. Husband; same address as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c) <b>Cardiovascular renal disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular renal disease</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				DATE SIGNED <b>May 3, 1959</b>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5 - 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Pasche Smith</b>				24a. REC'D BY REGISTRAR <b>May 6 '59</b>			
ADDRESS <b>Hyattsville Md</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hawk</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

*[Handwritten notes and signatures follow]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G243 5/27/59 cap

05898

5935

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. LENGTH OF STAY IN 1b <u>40 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON - 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Taint Branch Nursing Home</u>				d. STREET ADDRESS <u>7526-12th NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tillie (none) Hyman</u>				4. DATE OF DEATH Month Day Year <u>May 16 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 12, 1885</u>	
9. AGE (If years last birthday) <u>74 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sandler</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Nursing Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 30, 1958</u> , to <u>MAY 16, 1959</u> , that I last saw the deceased alive on <u>MAY 14, 1959</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>				DATE SIGNED <u>5/16/59</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>				<u>WASH 12 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-18-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>ATLANTIC-NAT.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY &amp; SONS WASH-DC</u>				ADDRESS <u>3501-14th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

FOR STATE  
HEALTH DEPT.

5936

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>		LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4315 Silver Hill Rd</u>				d. STREET ADDRESS <u>4315 Silver Hill Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Matilda</u> Last <u>S. Ingram</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt Home</u>		11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Holland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Maria Van Hasselt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Maries I. Weight, nurse</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause lost. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 18, 1959</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home, Mt. Rainier</u>				24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur I. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5937

## CERTIFICATE OF DEATH

05900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>3 years, 1 month, &amp; 26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1237 D. St., N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>L.</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>5</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/1927</b>
9. AGE (In years last birthday) <b>31 yrs.</b>		10. IF UNDER 1 YEAR Months <b>=</b> Days <b>=</b> Hours <b>=</b> Min. <b>=</b>	11. IF UNDER 24 HRS. Months <b>=</b> Days <b>=</b> Hours <b>=</b> Min. <b>=</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wool Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martinizing Cleaners</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marshall Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Locker Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-30-7384</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary tuberculosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>3 years and 6 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/15</b> , 19 <b>56</b> , to <b>5/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/12</b> , 19 <b>59</b> , and that death occurred at <b>2:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>5/12/59</b> ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> <b>Glenn Dale, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Val</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. Crouch</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>M. Arthur L. Kline</b>			



FOR STATE  
HEALTH DEPT.

5900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>37 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nannie M. Johnston</b>		4. DATE OF DEATH Month Day Year <b>May 29 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-74</b>
9. AGE (in years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Martha Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Blanche M. Shirley; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured hip with hip nailing operation</b> DUE TO (c) <b>r</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>xx</b> <b>12.15 p. m. 4-- 8-- 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (Nursing)</b>	20f. (City or town) (County) (State) <b>Takoma Park, Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John J. Maloney</b>		DATE SIGNED <b>May 30, 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Switland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b>	
ADDRESS <b>Hyattsville, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2000

FOR STATE  
HEALTH DEPT.

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		Male		45		1914	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 North Street		Carpenter		Heart Disease		Natural	
PLACE OF DEATH		EDUCATION		SPECIAL INQUIRY		FINDINGS	
Home		High School		None		None	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF CORONER	
1914		J. H. Harris		J. H. Harris		J. H. Harris	
PLACE OF EXAMINATION		FINDINGS		FINDINGS		FINDINGS	
Home		None		None		None	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF CORONER	
1914		J. H. Harris		J. H. Harris		J. H. Harris	
PLACE OF EXAMINATION		FINDINGS		FINDINGS		FINDINGS	
Home		None		None		None	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05902

5938

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hillcrest Heights</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5221-32nd Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hillcrest Heights</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hillcrest Heights</u> d. STREET ADDRESS <u>5221-32nd Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Kenneth Vaskin KAYIAN</u> First Middle Last <b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec 28, 1904</u> <b>9. AGE</b> (In years last birthday) <u>54</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laundry</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self Employed Conn</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. C.</u>				<b>4. DATE OF DEATH</b> <u>May 1</u> 19 <u>59</u> Month Day Year <b>13. FATHER'S NAME</b> <u>Artin KAYIAN</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Kri KORIAN</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>041-10-15231</u> <b>17. INFORMANT</b> <u>Margaret Kayian, mother</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> (b) <u>Bronchogenic Carcinoma</u> (c) <u>Bronchogenic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour o. m. p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> <b>EXAMINER'S NAME (Type)</b> <u>JAMES I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>May 2, 1959</u> DATE SIGNED			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>May 5, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Switland Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lee Son</u> ADDRESS <u>Wash. D. C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>MAY 6 '59</u> DATE		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05903

5901

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly 38</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>2303 Belleview Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>M.</b> Last <b>King</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 29, 1889</b>		9. AGE (In years lost birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Dorothy Ottaviano</b> <b>2303 Belleview Ave, Cheverly, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEUROGENIC SHOCK</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LEFT FRONTAL-PARIETAL CEREBRAL HEMORRHAGE</b> DUE TO <b>THROMBOSIS</b> (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b> <b>7 DAYS</b> <b>1 YEAR</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 MAY 1959</b> , to <b>30 MAY 1959</b> , that I last saw the deceased alive on <b>29 MAY 1959</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>905 SHERIDAN ST. HYATTSVILLE, MD.</b> DATE SIGNED <b>5/30/59</b> ACTUAL SIGNATURE <b>Henry R. Wolfe</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. H/ R. Wolfe</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith Jones Co.</b>				24a. REC'D BY REGISTRAR <b>2401-14th St NW</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kinn</b>	

I.

5

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 See: Birth Cert. et

05904

5902

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Linus</b> Middle <b>Lakshmanan</b> Last <b>Lakshmanan</b>				4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 May 1959</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Sitarama Lakshmanan</b>				14. MOTHER'S MAIDEN NAME <b>Florence Mary Lazicki</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mult. pul + renal infarct</b> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1, 1959</b> , to <b>May 20, 1959</b> , that I last saw the deceased alive on <b>May 19, 1959</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis Mendel</b> M.D. <b>4506 College Ave</b> <b>5/20/59</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Dr. R.A. Mendel, M.D.</b> <b>College Park Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>5/21/59</b>		<b>Gate of Heaven</b>		<b>Wheaton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Buscha Sons Hyattsville Md</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077304XV4

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1902

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5903

## CERTIFICATE OF DEATH

05905

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>5114 54th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>M.</b> Last <b>Lawrence</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Alvin Marlin</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Charles E. Lawrence, Sr. Roger Heights, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary vascular accident &amp; left hemiplegia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension Cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cholecyctis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19 59</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>5-20-59</b> , 19 <b>59</b> , to <b>5-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-30</b> , 19 <b>59</b> , and that death occurred at <b>12:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>T. H. Bergemann</b> M.D. <b>4314 fallon st</b> PHYSICIAN'S NAME (Type) <b>Dr. Till Bergemann</b> <b>H. G. Thibault M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co</b>				ADDRESS <b>2901-14th St NW</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

# STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. 5903 CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DATE OF INTERMENT [Faint text]</p>		<p>PLACE OF INTERMENT [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>DATE OF SIGNATURE [Faint text]</p>	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD., AND A COPY OF IT IS TO BE FURNISHED TO THE OFFICE OF THE STATE ARCHIVIST, BALTIMORE, MD.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5939

## CERTIFICATE OF DEATH

05906

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>None</u> Md b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 25 DC</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X None Mitchellville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>		d. STREET ADDRESS <u>1 None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Darron St. Claire Lee N/B</u>		4. DATE OF DEATH Month Day Year <u>May 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 May 59</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard N. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Agatha B. Mills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address <u>Route 2 Box 87, Mitchellville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Congenital Atelectasis</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 May</u> , 19 <u>59</u> , to <u>16 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>16 May</u> , 19 <u>59</u> , and that death occurred at <u>4:07 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John A. Moore</u> M.D.		USAF Hospital Andrews	
PHYSICIAN'S NAME (Type) <u>JOHN A MOORE CAPT USAF (MC)</u>		<u>Andrews AFB., Washington 25, DC</u>	
22a. BURIAL-CREMAATION, REMOVAL (Specify) <u>5-20-59</u>		22b. DATE THEREOF <u>ARDLINGTON</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARDLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>ARDLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. ERNEST JARVIS</u>		ADDRESS <u>P.O. 1432 You St, Md</u>	
24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>	

2050282XV1

2  
FOR  
HEAL!

please  
Page  
files.  
Henn.

XAMINER: This certificate should be executed within 24 hours after death. If any delay is writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral a to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for 18; Page 3 should be used as a burial-trar File pages 1 and 2 with the State R

TO DEPUTY MEDICA  
execute the certifi  
4 should be forw  
TO FUNERAL DIP"

VS. A15ME  
5M 2/57

STATE  
H DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Radiant Valley-Hyattsville</b>			c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6916 Shepherd Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>J.</b> Last <b>Light</b>			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1875</b>		9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Morrison</b>			14. MOTHER'S MAIDEN NAME <b>Julia Blackin</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Clinton G. Light; same address as # 2.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive-arteriosclerotic heart disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch s Sons Hyattsville Maryland.</b>			24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10034

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2803



1904

Residence - Springfield

Residence - Springfield

Age - 35

Age - 35

33

11

11

11

11

11

11

11, 12, 13

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

## 5940 CERTIFICATE OF DEATH

Reg. Dist. No. 05908

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Daisy Lane Route #1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROLAND FRANCIS LIVINGSTON</b>				4. DATE OF DEATH Month Day Year <b>May 16, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1907</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Business</b>		11. BIRTHPLACE (State or foreign country) <b>Allen, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter F. Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Annie B. Teadbin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-7044</b>		17. INFORMANT Address <b>Bowie, Md.</b> <b>Mrs. Freida B. Livingston, Daisy Lane, Route 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>POLYCYTHEMIA</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/3</b> , 19 <b>50</b> , to <b>5/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/14</b> , 19 <b>59</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Louis Mendel</b> M.D.				ADDRESS (Street, city or town, state) <b>4506 College Ave</b> DATE SIGNED <b>5/17/59</b>			
PHYSICIAN'S NAME (Type) <b>C. LOUIS MENDEL</b>				COLLEGE PARK Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>May 20, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arnon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forestville, Maryland, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Maryland,</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>C. Louis Mendel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1905	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TIME OF DEATH	
JAN 20 1950		BALTIMORE, MD		10:00 AM		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1950		JAN 20 1950		JAN 20 1950		JAN 20 1950	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN		ADDRESS OF PHYSICIAN		ADDRESS OF WITNESS	
BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF DEATH		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1905		JAN 20 1950		JAN 20 1950		JAN 20 1950	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL		NATURAL		NATURAL	



## 5941 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>				c. LENGTH OF STAY IN 1b <b>54 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6703--Allentown Rd. S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>LONG</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1872</b>	
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Emily Wood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Mabel L. Oursler 6703--Allentown Rd., SE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Dis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoporosis, marked</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4</b> 19 <b>58</b> , to <b>3/27</b> 19 <b>59</b> , that I last saw the deceased alive on <b>3/27</b> 19 <b>59</b> , and that death occurred at <b>843 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John T. Lyons</b>				ADDRESS (Street, city or town, state) <b>5241 St. Eustace Rd. F21M</b>			
DATE SIGNED <b>5/22/59</b>							
PHYSICIAN'S NAME (Type) <b>John T. Lyons</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-30-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bells Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Camp Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b> ADDRESS <b>1661--Good Hope Rd., SE Washington 20, DC</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05910

5904

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>	
c. LENGTH OF STAY IN 1b <b>2 hours</b>		d. STREET ADDRESS <b>8609 22nd Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Creighton</b> Last <b>Lyle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-1929</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lithographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lithograph</b>	
11. BIRTHPLACE (State or foreign country) <b>Dist. of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Lyle</b>		14. MOTHER'S MAIDEN NAME <b>Phyllis Paddock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.2</b>		16. SOCIAL SECURITY NO. <b>577-36-1441</b>	
17. INFORMANT <b>John E. Lyle; Hyattsville, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severence of right femoral artery and</b> (c) <b>Cerebral concussion and contusion</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operator of a motorcycle in collision with a 1957 Ford Convert.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>3:00</b> o. m. <b>May 22 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>near Glen Dale, Pr. Geo. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 22, 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Geers Sons Co</b>		24a. REC'D BY REGISTRAR <b>May 25 '59</b>	
ADDRESS <b>3605-14 St NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John T. Jones		Male		35		12-15-1895	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician's Signature	
12-20-1932		10:30 AM		Home		J. T. Jones	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
J. T. Jones		J. T. Jones		J. T. Jones		J. T. Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

FOR STATE  
HEALTH DEPT.

5942

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Vista</b>		c. LENGTH OF STAY IN 1b <b>transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>John Hansen Highway</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47x.3	
3. NAME OF DECEASED (Type or print) First <b>Kermit</b> Middle <b>Martin</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-4-12</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. 2</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Melda W. Martin; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Laceration of scalp and cerebral concussion.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>A passenger in an automobile in collision with a sand bank.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-2-59</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Near Vista, Pr. Geo. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 2, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Arlington Va.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James W. Edmonson</b>		ADDRESS <b>909 6th St. N.W.</b>	
24a. REC'D BY REGISTRAR <b>May 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Decedent's Name: \_\_\_\_\_

Residence: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Education: \_\_\_\_\_

Religion: \_\_\_\_\_

Usual Place of Abode: \_\_\_\_\_

Usual Place of Employment: \_\_\_\_\_

Usual Place of Recreation: \_\_\_\_\_

Usual Place of Social Life: \_\_\_\_\_

Usual Place of Travel: \_\_\_\_\_

Usual Place of Residence: \_\_\_\_\_

Usual Place of Employment: \_\_\_\_\_

Usual Place of Recreation: \_\_\_\_\_

Usual Place of Social Life: \_\_\_\_\_

Usual Place of Travel: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

05912

5905

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	c. LENGTH OF STAY IN lb <b>9 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>4911 Fox St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>L.</b> Last <b>McGOWAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1875</b>
9. AGE (In years lost birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Kansas, Oskaloosa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John O. Lyon</b>	
14. MOTHER'S MAIDEN NAME <b>Lucille Johnson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rose P. Bryant, daughter, 4911 Fox St, Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO <b>sudden death</b> (c) <b>arterio sclerotic heart dis.</b> DUE TO <b>2 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 11, 1959</b> , to <b>MAY 25, 1959</b> that I last saw the deceased alive on <b>MAY 25, 1959</b> , and that death occurred at <b>1243</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Riverdale, Md.</b> DATE SIGNED <b>5/26/59</b>			
ACTUAL SIGNATURE <b>L. W. Malin</b> M.D.		PHYSICIAN'S NAME (Type) <b>L. W. MALIN, M. D.</b> <b>Riverdale, Maryland.</b> <b>5/26/59</b>	
22a. BURIAL CREMATION <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS COMPANY, Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Finner</b>			

CERTIFICATE OF DEATH

1905

46

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		MARRIAGE Married	
DATE OF DEATH Jan 15, 1905		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
CAUSE OF DEATH Heart Disease		DISEASE Myocardial Infarction		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical attention		HISTORY No previous illness	
SIGNATURE OF PHYSICIAN Dr. J. Smith		SIGNATURE OF WITNESSES John Doe, Jane Doe		SIGNATURE OF DECEASED John Doe		SIGNATURE OF CLERK John Doe		SIGNATURE OF REGISTRAR John Doe	
DATE OF SIGNATURE Jan 15, 1905		DATE OF SIGNATURE Jan 15, 1905		DATE OF SIGNATURE Jan 15, 1905		DATE OF SIGNATURE Jan 15, 1905		DATE OF SIGNATURE Jan 15, 1905	

FOR STATE  
HEALTH DEPT.

5943

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City, Md.</b>				c. LENGTH OF STAY IN 1b <b>transient</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>N.W. branch of Anacosta River</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Patrick</b> Last <b>McGowan</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-09</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet metal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet metal</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick McGowan</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Burns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-09-6972</b>		17. INFORMANT <b>Leonard W. Crawford; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>9298</b> IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Thrombosis of Basilar Artery</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collapsed while walking in shallow water, fell face downward.</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>May 1959</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) <b>Cottage City, Pr. Geo. Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 24, 1959</b>	
22a. BURIAL, CREMATION, or other disposition <b>Transportation</b>		22b. DATE THEREOF <b>5/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gallitzin</b>		22d. LOCATION (City, town, or county) (State) <b>Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch*s Sons</b>				ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR <b>MAY 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
c. LENGTH OF STAY IN TB <b>5 months</b>		d. STREET ADDRESS <b>5811 MAIDEN LANE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR (HOME FOR AGED)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>C.</b> Last <b>MC KEE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-5-1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL CONNER</b>		14. MOTHER'S MAIDEN NAME <b>WINIFRED MC NAMARA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>4922 LaSalle Rd.</b>		18. NAME OF DECEASED <b>SR. M. FRANCIS PATRICIA CARROLL MANOR</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC-HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>55</b> , to <b>May 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 2</b> , 19 <b>59</b> , and that death occurred at <b>8:30</b> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F Collins</b>		ADDRESS (Street, city or town, state) <b>322 H N NE</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS F COLLINS</b>		DATE SIGNED <b>5-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-11-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Wash D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm Lees Sons Co</b>		ADDRESS <b>300-4th st &amp; E Wash &amp; D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

090

1

1

05910

CENTRE OF DEATH

05710

WILLIAM J. JONES





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05915

5906

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	c. LENGTH OF STAY IN 1b <b>13 x - 2</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel - rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Laurel Hospital</b>		d. STREET ADDRESS <b>RFD #1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>RAYMOND</b> Last <b>MILES</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Richard Miles</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Sewell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>212-16-8001</b>		17. INFORMANT <b>Mrs Emma Miles RFD 1 Laurel Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Chest.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) <b>981X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot during attempted robbery.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during attempted robbery.</b>	
20c. TIME OF INJURY Hour <b>10:10</b> Minute <b>10</b> P. M. <b>5/8 1959</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Store</b>	20f. (City or town) (County) (State) <b>Howard Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		DATE SIGNED <b>5/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ingalls Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Laurel Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Carleton</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3000

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
OCCASION OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
ADDRESS OF DECEASED [Faint text]		CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]		[Faint text]	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

5907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>820 N. Fulton Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Morrow</b> Last <b>Morrow</b>		4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3-1888</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Morrow</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital Records Laurel Sanitarium</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy (334)</b> DUE TO <b>cerebral arteriosclerosis (334)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>several hrs.</b> (c) <b>several yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency (325)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>May-17-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May-17</b> , 19 <b>59</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Erika P. Kraemer</b> M.D.		DATE SIGNED <b>5-17-59</b>	
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		Address <b>Laurel Sanitarium Maryland</b>	
22a. BURIAL OR CREMATION REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		24b. REGISTRAR'S SIGNATURE	
24a. REC'D BY REGISTRAR		DATE <b>MAY 19 59</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5819

## CERTIFICATE OF DEATH

05917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale</i>		c. LENGTH OF STAY IN 1b <i>2 yrs 7 mo</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glenn Dale Hospital</i>		d. STREET ADDRESS <i>805 "T" St. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EVELYN</i> First Middle <i>MUMFORD</i> Last		4. DATE OF DEATH Month <i>5</i> Day <i>8</i> Year <i>19 59</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/22/08</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>service</i>	
11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Edward Bacon</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Day</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>deceased</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Tuberculosis</i> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs 4 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia, both lungs; Diabetes mellitus; Gangrene Rt. Fifth toe</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 28.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/29</i> , 19 <i>56</i> , to <i>5/8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/8</i> , 19 <i>59</i> , and that death occurred at <i>11:10 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>MOE WEISS</i>		M.D. <i>Glenn Dale Hospital</i> DATE SIGNED <i>5/9/59</i>	
PHYSICIAN'S NAME (Type) <i>MOE WEISS M.D.</i>		<i>Glenn Dale, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal to D.C.</i>		22b. DATE THEREOF <i>5/9/59</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Bacon</i>		ADDRESS <i>1722 7th St. N.W. D.C.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	





## 5908 CERTIFICATE OF DEATH

Reg. Dist. No.

05918

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William C Nesgoda</b>				4. DATE OF DEATH <b>May 19 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/1917</b>	
9. AGE (In years last birthday) <b>41</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONN.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert Nesgoda</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>223-38-1315</b>			
17. INFORMANT <b>Margaret J. Nesgoda, Wife</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Occlusion of Left Anterior Descending Coronary</b> DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hours</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct. 28</b> , 19 <b>55</b> , to <b>May 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 19</b> , 19 <b>59</b> , and that death occurred at <b>4:35 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Kauffman</b> M.D.				ADDRESS (Street, city or town, state) <b>5102 Annapolis Rd. Bladensburg Md.</b>			
DATE SIGNED <b>5/19/59</b>							
PHYSICIAN'S NAME (Type) <b>Julius Kauffman</b>				5102 Annapolis Rd. Bladensburg Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>P. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers CO.</b> ADDRESS <b>5801 CLEVELAND AVE RIVER DALE MD</b>				24a. REC'D BY REGISTRAR <b>MAY 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

60118

See Title for Instructions

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Cause of Death		8. Manner of Death		9. Signature of Registrar		10. Signature of Physician	
John Doe		Male		45		1/1/1920		1/15/1965		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital Status		14. Usual Residence		15. Usual Address		16. Usual Telephone		17. Usual Religion		18. Usual Race		19. Usual Color		20. Usual Ethnicity	
Teacher		High School		Married		Baltimore, Md.		1234 Main St.		(123) 456-7890		Roman Catholic		White		Caucasian		Caucasian	
21. Usual Religion		22. Usual Race		23. Usual Color		24. Usual Ethnicity		25. Usual Religion		26. Usual Race		27. Usual Color		28. Usual Ethnicity		29. Usual Religion		30. Usual Race	
Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White	
31. Usual Color		32. Usual Ethnicity		33. Usual Religion		34. Usual Race		35. Usual Color		36. Usual Ethnicity		37. Usual Religion		38. Usual Race		39. Usual Color		40. Usual Ethnicity	
Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian	
41. Usual Religion		42. Usual Race		43. Usual Color		44. Usual Ethnicity		45. Usual Religion		46. Usual Race		47. Usual Color		48. Usual Ethnicity		49. Usual Religion		50. Usual Race	
Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White	
51. Usual Color		52. Usual Ethnicity		53. Usual Religion		54. Usual Race		55. Usual Color		56. Usual Ethnicity		57. Usual Religion		58. Usual Race		59. Usual Color		60. Usual Ethnicity	
Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian	
61. Usual Religion		62. Usual Race		63. Usual Color		64. Usual Ethnicity		65. Usual Religion		66. Usual Race		67. Usual Color		68. Usual Ethnicity		69. Usual Religion		70. Usual Race	
Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White	
71. Usual Color		72. Usual Ethnicity		73. Usual Religion		74. Usual Race		75. Usual Color		76. Usual Ethnicity		77. Usual Religion		78. Usual Race		79. Usual Color		80. Usual Ethnicity	
Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian	
81. Usual Religion		82. Usual Race		83. Usual Color		84. Usual Ethnicity		85. Usual Religion		86. Usual Race		87. Usual Color		88. Usual Ethnicity		89. Usual Religion		90. Usual Race	
Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White		Caucasian		Caucasian		Roman Catholic		White	
91. Usual Color		92. Usual Ethnicity		93. Usual Religion		94. Usual Race		95. Usual Color		96. Usual Ethnicity		97. Usual Religion		98. Usual Race		99. Usual Color		100. Usual Ethnicity	
Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian		Roman Catholic		Caucasian		Caucasian		Caucasian	

1

## 5944 CERTIFICATE OF DEATH

05919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>932</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1028-University Blvd. East</u>		d. STREET ADDRESS <u>1028-University Blvd. East</u>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>Nilson</u> Middle <u>Nicholson</u> Last		4. DATE OF DEATH <u>May 2nd</u> 19 <u>59</u> Month <u>May</u> Day <u>2nd</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/1895</u>
9. AGE (In years, lost birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Det. Sergh, retired Met. Police Dept.</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Nicholson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Kyle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Paul E. Nicholson, son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cronary heat disease</u> (c) <u>Cronary heat disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1946</u> , 19 <u>59</u> , to <u>May 2nd</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 9</u> , 19 <u>59</u> , and that death occurred at <u>1506</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Magruder MacDonald</u> M.D.		ADDRESS (Street, city or town, state) <u>1746 R St NW</u>	
PHYSICIAN'S NAME (Type) <u>A Magruder MacDonald</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colma Manor, Md.</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>Kallop's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>May 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5874

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		c. LENGTH OF STAY IN lb <b>40 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier</b>		d. STREET ADDRESS <b>4216 30th Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4216 30th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gregory</b> Middle <b>Aloysius</b> Last <b>O'Connor</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-18 90</b>
9. AGE (In years for birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas O'Connor</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Josephine O'Connor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>577-28-2231</b>		17. INFORMANT <b>Gregory A. O'Connor, Jr.</b> Address <b>Silver Springs, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion and edema</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary embolism</b> DUE TO (c) <b>Coronary occlusion, cardiovascular renal disease.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 15, 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hallen's Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 18 '59</b>	
ADDRESS <b>Home Mt. Rainier Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1945-10-15	
Place of Birth		County		State		Manner of Death	
New York		Westchester		New York		Natural	
Occupation		Education		Religion		Cause of Death	
Teacher		High School		Roman Catholic		Heart Disease	
Usual Residence		Address		City		County	
123 Main St		123 Main St		New York		Westchester	
Physician		Hospital		Burial Place		Interment	
Dr. Smith		St. Mary's		St. Mary's		Buried	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be placed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05921

5909

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Beaufort</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>245 E 2nd St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace (N.M.N.) O'Neal (O'Neil)</u>				4. DATE OF DEATH Month Day Year <u>May 27 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Jan 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Jessie J. Warren</u>				14. MOTHER'S MAIDEN NAME <u>Helen Ricks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Mary D. Gray, 5708--84th St. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Slipoma, right cerebral</u> <u>193.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>May 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>59</u> , and that death occurred at <u>4:55 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Mendelsohn</u>				ADDRESS (Street, city or town, state) <u>1904 "R" ST., NW., WASH DC</u>			
DATE SIGNED <u>5/27/59</u>							
PHYSICIAN'S NAME (Type) <u>Robert A. Mendelsohn M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29th, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, Beaufort Co., N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



5910

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Naylor Gardens (Wash. 20, D.C.)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 2714--29th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEON Middle R. Last PALEY				4. DATE OF DEATH Month May 21, 1959 Day 19 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13th, 1916		9. AGE (in years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician		10b. KIND OF BUSINESS OR INDUSTRY Census Bureau		11. BIRTHPLACE (State or foreign country) Bronx, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Paley				14. MOTHER'S MAIDEN NAME Rose (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Ruth Paley, 2714--29th St. Washington 20, D.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED May 22, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons-3501 14th St., N.W.				24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



1931, 1932, 1933

DEATH CERTIFICATE  
No. 12345  
DATE OF DEATH  
JAN 12 1934

CAUSE OF DEATH  
Heart Disease

DEATH CERTIFICATE  
No. 12345  
DATE OF DEATH  
JAN 12 1934

DEATH CERTIFICATE  
No. 12345  
DATE OF DEATH  
JAN 12 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		c. LENGTH OF STAY IN 1b <i>7 1/2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George Huntley Palmer</i>		4. DATE OF DEATH Month Day Year <i>May 3 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 8, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sacristan</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Fredrick Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Ann Susanna Huntley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-44-2973</i>	
17. INFORMANT <i>St. Maureen Therese</i>		Address <i>Carroll Manor</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aesophageal Hemorrhage</i> 539.1 DUE TO <i>Relaxation of Aesophageal Structure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Aesophagitis</i> (c) <i>Aesophagitis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardiovascular Disease</i> <i>Gastric resection (1954)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>2 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 2</i> , 19 <i>59</i> , to <i>May 3</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 2</i> , 19 <i>59</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francis P. Hannan M.D.</i>		ADDRESS (Street, city or town, state) <i>1511-17 St. N.W. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>FRANCIS P. HANNAN, M.D.</i>		DATE SIGNED <i>May 3, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5-6-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lambersons</i>		ADDRESS <i>1756 Va Ave NW</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

RECEIVED

5871

CERTIFICATE OF DEATH

05083



## CERTIFICATE OF DEATH

Reg. Dist. No.

05924

5945

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Takoma Park		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1525 Elson St. Takoma Park, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Rose Park		4. DATE OF DEATH May 17 1959	
5. SEX F	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 10, 1873
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dee		14. MOTHER'S MAIDEN NAME Mary Ann Panning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Catherine Gill		Address 1525 Elson St. Takoma Park	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardiovascular disease with congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956, to May 17 1959, that I lost s/he the deceased alive on May 17 1959, and that death occurred at 3:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. White, M.D.		DATE SIGNED 5-17-59	
PHYSICIAN'S NAME (Type) James H. White, M.D.		ADDRESS (Street, city or town, state) 7701 Carroll Ave Takoma Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP R.R.	22b. DATE THEREOF 5-20-1959	22c. NAME OF CEMETERY OR CREMATORY St. Raymonds Cemetery Bronx	22d. LOCATION (City, town, or county) (State) New York
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co 5801 Cleveland Ave		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
VS A15 (4) 15M 9/55		DATE MAY 20 1959	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF DEATH HOME		MARRIAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PLACE OF BIRTH HOME		PLACE OF DEATH HOME	
DATE OF BIRTH JAN 1 1900		DATE OF DEATH JAN 1 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH HOME		PLACE OF BIRTH HOME	
DATE OF BIRTH JAN 1 1900		DATE OF BIRTH JAN 1 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5946

CERTIFICATE OF DEATH

05925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>3918 Elm Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Perry</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Julius Jones</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John Perry —1225 1/2 Duncan St.; N.E. Wash; D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia (Renal failure) due to</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic heart disease with</b> DUE TO (c) <b>cardiomegaly and myocardial sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>see above</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>54</b> , to <b>7 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7 May</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3435 Benning Rd. N.E.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Arthur L. Harris</b>		M.D. <b>3435 Benning Rd. N.E.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Harris</b>		ADDRESS <b>30 H Street, N.E.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

# CERTIFICATE OF DEATH

1956

File No. 100

DECEASED NAME John Doe		SEX Male		RACE White		DATE OF BIRTH Jan 1, 1900		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Jan 15, 1925 Spouse: Jane Doe	
DECEASED NAME Jane Doe		SEX Female		RACE White		DATE OF BIRTH Feb 1, 1905		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Jan 15, 1925 Spouse: John Doe	
DECEASED NAME Robert Smith		SEX Male		RACE White		DATE OF BIRTH Mar 1, 1910		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Mar 1, 1935 Spouse: Mary Smith	
DECEASED NAME Mary Smith		SEX Female		RACE White		DATE OF BIRTH Apr 1, 1915		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Mar 1, 1935 Spouse: Robert Smith	
DECEASED NAME William Brown		SEX Male		RACE White		DATE OF BIRTH May 1, 1920		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: May 1, 1940 Spouse: Elizabeth Brown	
DECEASED NAME Elizabeth Brown		SEX Female		RACE White		DATE OF BIRTH Jun 1, 1925		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: May 1, 1940 Spouse: William Brown	
DECEASED NAME Charles Green		SEX Male		RACE White		DATE OF BIRTH Jul 1, 1930		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Jul 1, 1950 Spouse: Susan Green	
DECEASED NAME Susan Green		SEX Female		RACE White		DATE OF BIRTH Aug 1, 1935		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Jul 1, 1950 Spouse: Charles Green	
DECEASED NAME David White		SEX Male		RACE White		DATE OF BIRTH Sep 1, 1940		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Sep 1, 1960 Spouse: Linda White	
DECEASED NAME Linda White		SEX Female		RACE White		DATE OF BIRTH Oct 1, 1945		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Sep 1, 1960 Spouse: David White	
DECEASED NAME Thomas Black		SEX Male		RACE Black		DATE OF BIRTH Nov 1, 1950		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Nov 1, 1970 Spouse: Patricia Black	
DECEASED NAME Patricia Black		SEX Female		RACE Black		DATE OF BIRTH Dec 1, 1955		PLACE OF BIRTH New York, N.Y.		MARRIAGE Date: Nov 1, 1970 Spouse: Thomas Black	

30 R 25-52, H. 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G243 5/27/59 cap  
5947 CERTIFICATE OF DEATH

05926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3819-40th Avenue		d. STREET ADDRESS 13819-40th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francesco (Frank) PETRONE		4. DATE OF DEATH May 11 1959	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1876
9. AGE (In years lost birthday) 83 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Stanley		14. MOTHER'S MAIDEN NAME Marguerite Montello	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-18-1035	
17. INFORMANT Mrs. Yolanda Scarlato, Daughter		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Acute pulmonary edema DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of esophagus		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 6 mo. 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-11 1959, to 5-11 1959, that I last saw the deceased alive on 5-11 1959, and that death occurred at 11:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. D. Baker M.D.		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. DATE SIGNED 5-12-59	
PHYSICIAN'S NAME (Type) R. D. BAKER, M.D.		Adelphi Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/15/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Inc.		24a. REC'D BY REGISTRAR ADDRESS Mt. Rainier Md. DATE MAY 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED  
BALTIMORE  
MAY 19 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Race: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Manner of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 Film G243 6-5-59 et  
5911  
CERTIFICATE OF DEATH

05927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Tillie Pines		4. DATE OF DEATH Month Day Year May 28 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 2-1892 67
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rumania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Habot		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Julius Pines 7E Crescent Dr. Greenbelt Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MULTIPLE LUNG INFARCTIONS DUE TO (b) MYOCARDIAL INFARCTION (c) CORONARY INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 MO. 2 MOS. YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 MAY, 1959, to 27 MAY, 1959, that I last saw the deceased alive on 25 MAY, 1959, and that death occurred at 2:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry R. Wolfe M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 5/28/59	
PHYSICIAN'S NAME (Type) HENRY R. WOLFE		HYATTSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29-1959	
22c. NAME OF CEMETERY OR CREMATORY Mt Hebron		22d. LOCATION (City, town, or county) (State) Long Detour N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Golding Funeral Home 4217 9th MD		24a. REC'D BY REGISTRAR DATE JUN 1 59	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

2011

DATE OF DEATH

PLACE OF DEATH

DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05928

Reg. Dist. No.

5912

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>8 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Landover Hills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>4600 72nd Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marvin Lee Reed</b>				4. DATE OF DEATH Month Day Year <b>May 18 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 Nov. 1904</b>	
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Terminal</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>A W Reed</b>				14. MOTHER'S MAIDEN NAME <b>Bertha</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>417 03 4047</b>		17. INFORMANT Address <b>Lora C Reed Landover Hills, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sp. encephalomyelitis LUL RUL</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Branchio spai Can. RUL. i</b> DUE TO (c) <b>metastasis to brain</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (6) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>9/15</b> , 19 <b>46</b> , to <b>5/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/17</b> , 19 <b>59</b> , and that death occurred at <b>6.00 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. C.L. Mendel</b>				ADDRESS (Street, city or town, state) <b>4506 College Ave</b>			
PHYSICIAN'S NAME (Type) <b>Dr. C.L. Mendel, M.D.</b>				DATE SIGNED <b>5/18/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch s Sons</b>				ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove corbair papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X50

FOR STATE  
HEALTH DEPT.

5948

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05929

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Spring D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookridge Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Air Force Hospital</u>				d. STREET ADDRESS <u>4804 V Street SE</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Robert</u> Last <u>Reid</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6, 1940</u>	
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		IF UNDER 24 HRS. Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School Washington DC</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Robert Reid</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Name <u>Mrs Elizabeth Notestine</u> Address <u>same as 13</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Choking</u> DUE TO (c) <u>Choking</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>War swimming in a pond with some other boys</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>War swimming in a pond with some other boys</u>					
20c. TIME OF INJURY Hour <u>11:40</u> a. m. <u>5/28/58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond</u>		20f. (City or town) <u>with V. Lee P. Rd</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>5/28/58</u>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 1-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Suitland Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				ADDRESS <u>1661-9th Hopedale</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
				DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1948

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. NAME OF DECEASED: [Blank]

2. SEX: [Blank]

3. AGE: [Blank]

4. DATE OF BIRTH: [Blank]

5. PLACE OF BIRTH: [Blank]

6. OCCUPATION: [Blank]

7. CAUSE OF DEATH: [Blank]

8. MANNER OF DEATH: [Blank]

9. SIGNATURE OF EXAMINER: [Blank]

10. DATE OF EXAMINATION: [Blank]

11. PLACE OF EXAMINATION: [Blank]

12. SIGNATURE OF WITNESS: [Blank]

13. DATE OF SIGNATURE: [Blank]

14. PLACE OF SIGNATURE: [Blank]

15. SIGNATURE OF JUDGE: [Blank]

16. DATE OF SIGNATURE: [Blank]

17. PLACE OF SIGNATURE: [Blank]

18. SIGNATURE OF CLERK: [Blank]

19. DATE OF SIGNATURE: [Blank]

20. PLACE OF SIGNATURE: [Blank]

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT AND IS NOT VALID FOR ANY OTHER PURPOSE.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5949

CERTIFICATE OF DEATH

Reg. Dist. No. 05930

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4919 RUSSELL AVE</u>				d. STREET ADDRESS <u>14919 RUSSELL AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS EDWARD RICKER</u>				4. DATE OF DEATH Month Day Year <u>MAY 15 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20, 1887</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED WASH TERMINAL RAIL ROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN LAWRENCE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN ISABELLE BINNIX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>THOMAS B. RICKER</u> Address <u>4301 VAN BUREN ST. UNIVERSITY PARK, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis-</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease-</u> DUE TO (c) <u>Diabetes Mellitus-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>23 months</u> <u>23 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/18/1957</u> , 19____, to <u>5/15/1959</u> , 19____, that I lost s/he the deceased alive on <u>5/15/1959</u> , 19____, and that death occurred at <u>4:20 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>322- H. St. N.E.</u>			
PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>				<u>Washington 2, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-18-59</u>		<u>St. Mary's</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH - ONE TO 10

## CERTIFICATE OF DEATH

PLACE OF BIRTH (State, Territory, Possession, or Foreign Country)		DATE OF BIRTH (Month, Day, Year)	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		RACE (Specify race)	
NAME OF DECEASED (Full name, including middle name and initials)		NAME OF FATHER (Full name, including middle name and initials)	
NAME OF MOTHER (Full name, including middle name and initials)		PLACE OF BIRTH OF FATHER (State, Territory, Possession, or Foreign Country)	
PLACE OF BIRTH OF MOTHER (State, Territory, Possession, or Foreign Country)		DATE OF DEATH (Month, Day, Year)	
TIME OF DEATH (Hour, Minute)		PLACE OF DEATH (Specify place)	
CAUSE OF DEATH (Specify cause)			
MANNER OF DEATH (Specify manner)			
SIGNATURE OF DECEASED (If deceased is capable of signing)			
SIGNATURE OF FATHER (If father is capable of signing)			
SIGNATURE OF MOTHER (If mother is capable of signing)			
SIGNATURE OF PHYSICIAN (If physician is capable of signing)			
SIGNATURE OF CLERK (If clerk is capable of signing)			
SIGNATURE OF REGISTRAR (If registrar is capable of signing)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 13, 14 Film G243 6-8-59 et  
**CERTIFICATE OF DEATH**

05931

5913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Hgts</b>		c. LENGTH OF STAY IN 1b <b>34 Capitol Hgts.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>618 - 57th Ave.</b>		d. STREET ADDRESS <b>618 - 57th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>C.</b> Last <b>RIPLEY</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30th</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1880</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book binder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.P.O.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cameron, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>"Unable to obtain from family"</b>		14. MOTHER'S MAIDEN NAME <b>"Unable to obtain from family"</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Frances R Ripley</b>		Address <b>- same as above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute ecchymosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-25</b> , 19 <b>59</b> , to <b>5-30-59</b> , that I last saw the deceased alive on <b>5-29-59</b> , 19 <b>59</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John B. Feban</b> M.D. <b>5-30-59</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>JOHN B FEBAN</b>		<b>2210 NICHOLS AVE S.W. WASH DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>		ADDRESS <b>24a. REC'D BY REGISTRAR DATE JUN 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

• • •

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05932

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leellon Park</u> c. LENGTH OF STAY IN 1b <u>18 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5107 G Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leellon Park</u> d. STREET ADDRESS <u>5107-G Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Bernard</u> Middle <u>Arthur</u> Last <u>Rock</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>15</u> Year <u>1959</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>January 30, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Instrument Maker &amp; Repair</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>England</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Fred Rock</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Mailland</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates at service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mary G. Rock, same as above</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to hanging</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in basement of home</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>8:30 p.m. 5/15 1959</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Leellon Park</u> <u>MD</u>									
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>																	
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>May 15, 1959</u>									
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u> <b>22b. DATE THEREOF</b> <u>May 18-59</u>													
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Southland Md</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Summers Bros</u>				<b>ADDRESS</b> <u>1661-90 Hopp</u>				<b>24a. REC'D BY REGISTRAR</b> <u>May 18 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and printed form fields are visible. The form includes sections for patient information, cause of death, and examiner details.]*

*[Faint handwritten text, possibly a signature or name, is visible in the lower right section of the form.]*



FOR STATE  
HEALTH DEPT.

5914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05933

Reg. Dist. No.

1. PLACE OF DEATH, a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Phillip</b> Last <b>Rode</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-28-15</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Programme Planner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service Commiss.</b>			
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Chester Rode</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Shekel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>390-16-1447</b>		17. INFORMANT Address <b>Susan Marie Rode; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Asthma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
<b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 11, 1959</b>			
22a. BURIAL, CREMATION, or other disposition of remains <b>Transportation</b>		22b. DATE THEREOF <b>5/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Owensboro</b>		22d. LOCATION (City, town, or county) (State) <b>Kentucky</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gaschs Sons</b>				ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 660 •

01507

• • • •

121

## 5872 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 MT. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE Convalescent &amp; Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl Christine Sampson</u>		4. DATE OF DEATH <u>May 16 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>	
11c. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Christine Brackman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Cecil Sampson - 3213 Varnum ST.</u>	
17. INFORMANT - <u>Son</u> Address <u>Cecil Sampson - 3213 Varnum ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> 19____, to <u>May 16</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 14</u> 19 <u>59</u> , and that death occurred at <u>7:34</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon L. Gallin MD</u> M.D.		ADDRESS (Street, city or town, state) <u>7206 Glenville Rd. W. Hyattsville</u> DATE SIGNED <u>Maryland</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5118-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>Washington D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Lee's Funeral Home 4 B &amp; C Sts. N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5951 CERTIFICATE OF DEATH

05935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Park</b>	
c. LENGTH OF STAY IN 1b <b>30 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4620 -Howe Ave. S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAMIE</b>		4. DATE OF DEATH <b>May 15th 19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10- 1888</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Informant</b> <b>Rufus H. Satterfield</b> Address <b>Same as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho - pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular accident</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1948</b> to <b>May 15, 1959</b> that I last saw the deceased alive on <b>May 14, 1959</b> , and that death occurred at <b>12-22-59</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5/15-59</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Bernard Katzen</b>		3550 Minn., Ave. S. E. Wash., D.C.	
PHYSICIAN'S NAME (Type) <b>BERNARD KATZEN</b>		3550- Minn.. Ave., S.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CHICK Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmars Brothers</b>		ADDRESS <b>1661- Good Hope Rd. S.E. Washington 20, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

**TABLE 1**

22



## 5952 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>8½ yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linden Street</u>		d. STREET ADDRESS <u>Linden Street</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> <u>First Karl</u> <u>Middle Schuerger</u> <u>Last</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John George Schuerger</u>	
14. MOTHER'S MAIDEN NAME <u>Dora W. Fensahrens</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>W.W.No. 1 1917</u>	
16. SOCIAL SECURITY NO. <u>217-34-0120</u>		17. INFORMANT <u>Wife</u> Address <u>Linden St. Clinton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, 3 weeks</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis 4 yrs.</u> DUE TO (c) <u>Mitral regurgitation 5 weeks</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>32</u> , to <u>May 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 19, 12 p.m. 1959</u> , and that death occurred at <u>7:30M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy F. Dunmire</u> M.D.		DATE SIGNED <u>5-20-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Roy F. Dunmire, 119 - 8th St. S. E. Wash. D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-22 59</u>	<u>Arlington National</u>	<u>Ft Myer, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be returned for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

5915

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comady Hills</u>	
c. LENGTH OF STAY IN 1b <u>death on arrival</u>		d. STREET ADDRESS <u>7321-7 ST NE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Earl</u> Last <u>Sealock</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Nov 7, 1929</u>	9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co</u>	11. BIRTHPLACE (State or foreign country) <u>District of Columbia U.S.A.</u>
13. FATHER'S NAME <u>Samuel Sealock</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Thomas Sealock, Boulevard Hts, Md</u>	
17. INFORMANT <u>800 Myers St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Fractured Skull</u> DUE TO <u>Fractured Skull</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Driver of auto that got out of control and turned over</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>May 5/10 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 75</u>	20f. (City or town) <u>Camp Springs P.D. Md</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>May 19 1959</u>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u>Southland Md</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Ave</u> ADDRESS <u>1661-40 Hope Rd SE</u>		24a. REC'D BY REGISTRAR <u>May 12 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

1

TO ORDER: THE SECRETARY OF THE ARMY, WASHINGTON, D.C. 20315

*[Faint handwritten notes at the bottom of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 5953 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Dist. of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glenn Dale Hosp.</i>		d. STREET ADDRESS <i>2556 University Pl. N.W.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JOSEPH HENRY SLAUGHTER</i>		4. DATE OF DEATH Month <i>5</i> Day <i>29</i> Year <i>19 59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/6/1877</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building Management</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Eli Slaughter</i>		14. MOTHER'S MAIDEN NAME <i>Ella Wethers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Deceased</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY FIBROSIS &amp; EMPHYSEMA</i> DUE TO <i>PULMONARY TUBERCULOSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>3 YRS</i> (c) <i>3 YRS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19 59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/27</i> , 19 <i>59</i> , to <i>5/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/29</i> , 19 <i>59</i> , and that death occurred at <i>9:00</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>MOE WEISS</i>		ADDRESS (Street, city or town, state) <i>Glenn Dale Hosp.</i>	
PHYSICIAN'S NAME (Type) <i>MOE WEISS M.D.</i>		DATE SIGNED <i>5/30/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-31-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Murray &amp; Sons</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>16073</i>		24b. REGISTRAR'S SIGNATURE <i>Anthony L. Thomas</i>	
DATE <i>16073</i>		Year <i>59</i>	





5954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1, Film G242 5/21/59 cap

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2423 E St NW - Washington DC</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>2423 E St NW - DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6229 Oxon Hill Rd, Private Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Smith</u> First Middle Last		4. DATE OF DEATH <u>May 12 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>So Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Morgan Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Sola Sanders</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Jay Smith</u> Address <u>2423 E St NW - DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c) <u>unknown</u> DUE TO (c) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Indigestion - Took alcohol before bed</u>	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Paul P. Vanatta</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>PAUL P. VANATTA</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5.18.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Smith</u>		24a. REC'D BY REGISTRAR <u>1820 9th St., N.W. Washington, D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>

08953

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6524

STATE OF MARYLAND  
DEPARTMENT OF HEALTH



Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several horizontal sections with various checkboxes and lines for text entry.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

RACE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

... (other fields) ...

FOR STATE  
HEALTH DEPT.

5916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05940

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>809 West Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Novella</b> Middle <b>Smith</b> Last <b>Smith</b>				4. DATE OF DEATH <b>May 23 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-08</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b>		IF UNDER 24 HRS. Hours <b>51</b> Min. <b>51</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William D. Rogers</b>				14. MOTHER'S MAIDEN NAME <b>Arcania Carroll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elitha Rogers; Rt. 1, Box 85 A, Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				DATE SIGNED <b>May 23, 1959</b>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beacon Chaple</b>		22d. LOCATION (City, town, or county) (State) <b>A.A. Co Laurel, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ridgley Selby Laurel Md. 1200 Snowden Pl.</b>				24a. REC'D BY REGISTRAR <b>MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05340

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

218

FOR STATE  
DEPT. OF HEALTH

Name of Deceased		John George	
Sex		Male	
Age		3 years	
Date of Birth		Jan 1, 1921	
Place of Birth		New York	
Usual Residence		100 West Street	
Cause of Death		Diphtheria	
Manner of Death		Natural	
Date of Death		Jan 1, 1922	
Place of Death		Home	
Physician		Dr. J. H. Brown	
Medical Examiner		Dr. J. H. Brown	
Signature of Medical Examiner		<i>[Signature]</i>	
Date of Examination		Jan 1, 1922	
Signature of Physician		<i>[Signature]</i>	
Date of Signature		Jan 1, 1922	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5917 CERTIFICATE OF DEATH

Reg. Dist. No.

05941

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>1317 Madison St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Rush</b> Last <b>Smoot</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12- -67</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper Gardiner</b>		11. BIRTHPLACE (State or foreign country) <b>Poolesville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Smoot</b>				14. MOTHER'S MAIDEN NAME <b>Margaret White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Nettie B. Smoot,</b>		Address <b>4317 Madison St., HYATTSVILLE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 yrs</b> <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-17-59</b> , 19 <b>59</b> , to <b>5-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-10-59</b> , 19 <b>59</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>640 43rd Ave Hyattsville Md.</b> DATE SIGNED <b>John P. Clum</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>May 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.</b> ADDRESS <b>RIVERDALE, MARYLAND.</b>			
24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5875

CERTIFICATE OF DEATH

Reg. Dist. No.

05942

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6805 Red Top Road</u>				d. STREET ADDRESS <u>6805 Red Top Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Lee</u> Last <u>Springmann</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1950</u>	9. AGE (In years lost birthday) <u>8</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min.	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fague K. M. Springmann</u>				14. MOTHER'S MAIDEN NAME <u>Vivian Loretta Willard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>F. K. M. Springmann</u> Address <u>Takoma Park Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver, Splenomegaly, ascites</u> 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemochromatosis</u> DUE TO (c) <u>Aplastic anemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u> <u>18 mo.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenic purpura and Nephrosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Dec. 10, 1958</u> , to <u>May 2, 1959</u> , that I last saw the deceased alive on <u>May 2, 1959</u> , and that death occurred at <u>5:32 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace N. Mook</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u>		DATE SIGNED <u>5/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Wallace N. Mook, M.D. Takoma Park 12 Maryland.</u>							
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. R. Domagala - Alex Va.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>	
4. PLACE OF BIRTH <u>NEW YORK</u>		5. DATE OF BIRTH <u>1910</u>		6. PLACE OF DEATH <u>NEW YORK</u>	
7. OCCUPATION <u>CLERK</u>		8. CAUSE OF DEATH <u>HEART DISEASE</u>		9. MANNER OF DEATH <u>NATURAL</u>	
10. DATE OF DEATH <u>1955</u>		11. TIME OF DEATH <u>10:00 AM</u>		12. PLACE OF INTERMENT <u>CATHOLIC CHURCH</u>	
13. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		14. SIGNATURE OF CORONER <u>[Signature]</u>		15. SIGNATURE OF REGISTRAR <u>[Signature]</u>	
16. SIGNATURE OF WITNESS <u>[Signature]</u>		17. SIGNATURE OF WITNESS <u>[Signature]</u>		18. SIGNATURE OF WITNESS <u>[Signature]</u>	
19. SIGNATURE OF WITNESS <u>[Signature]</u>		20. SIGNATURE OF WITNESS <u>[Signature]</u>		21. SIGNATURE OF WITNESS <u>[Signature]</u>	
22. SIGNATURE OF WITNESS <u>[Signature]</u>		23. SIGNATURE OF WITNESS <u>[Signature]</u>		24. SIGNATURE OF WITNESS <u>[Signature]</u>	
25. SIGNATURE OF WITNESS <u>[Signature]</u>		26. SIGNATURE OF WITNESS <u>[Signature]</u>		27. SIGNATURE OF WITNESS <u>[Signature]</u>	
28. SIGNATURE OF WITNESS <u>[Signature]</u>		29. SIGNATURE OF WITNESS <u>[Signature]</u>		30. SIGNATURE OF WITNESS <u>[Signature]</u>	
31. SIGNATURE OF WITNESS <u>[Signature]</u>		32. SIGNATURE OF WITNESS <u>[Signature]</u>		33. SIGNATURE OF WITNESS <u>[Signature]</u>	
34. SIGNATURE OF WITNESS <u>[Signature]</u>		35. SIGNATURE OF WITNESS <u>[Signature]</u>		36. SIGNATURE OF WITNESS <u>[Signature]</u>	
37. SIGNATURE OF WITNESS <u>[Signature]</u>		38. SIGNATURE OF WITNESS <u>[Signature]</u>		39. SIGNATURE OF WITNESS <u>[Signature]</u>	
40. SIGNATURE OF WITNESS <u>[Signature]</u>		41. SIGNATURE OF WITNESS <u>[Signature]</u>		42. SIGNATURE OF WITNESS <u>[Signature]</u>	
43. SIGNATURE OF WITNESS <u>[Signature]</u>		44. SIGNATURE OF WITNESS <u>[Signature]</u>		45. SIGNATURE OF WITNESS <u>[Signature]</u>	
46. SIGNATURE OF WITNESS <u>[Signature]</u>		47. SIGNATURE OF WITNESS <u>[Signature]</u>		48. SIGNATURE OF WITNESS <u>[Signature]</u>	
49. SIGNATURE OF WITNESS <u>[Signature]</u>		50. SIGNATURE OF WITNESS <u>[Signature]</u>		51. SIGNATURE OF WITNESS <u>[Signature]</u>	
52. SIGNATURE OF WITNESS <u>[Signature]</u>		53. SIGNATURE OF WITNESS <u>[Signature]</u>		54. SIGNATURE OF WITNESS <u>[Signature]</u>	
55. SIGNATURE OF WITNESS <u>[Signature]</u>		56. SIGNATURE OF WITNESS <u>[Signature]</u>		57. SIGNATURE OF WITNESS <u>[Signature]</u>	
58. SIGNATURE OF WITNESS <u>[Signature]</u>		59. SIGNATURE OF WITNESS <u>[Signature]</u>		60. SIGNATURE OF WITNESS <u>[Signature]</u>	
61. SIGNATURE OF WITNESS <u>[Signature]</u>		62. SIGNATURE OF WITNESS <u>[Signature]</u>		63. SIGNATURE OF WITNESS <u>[Signature]</u>	
64. SIGNATURE OF WITNESS <u>[Signature]</u>		65. SIGNATURE OF WITNESS <u>[Signature]</u>		66. SIGNATURE OF WITNESS <u>[Signature]</u>	
67. SIGNATURE OF WITNESS <u>[Signature]</u>		68. SIGNATURE OF WITNESS <u>[Signature]</u>		69. SIGNATURE OF WITNESS <u>[Signature]</u>	
70. SIGNATURE OF WITNESS <u>[Signature]</u>		71. SIGNATURE OF WITNESS <u>[Signature]</u>		72. SIGNATURE OF WITNESS <u>[Signature]</u>	
73. SIGNATURE OF WITNESS <u>[Signature]</u>		74. SIGNATURE OF WITNESS <u>[Signature]</u>		75. SIGNATURE OF WITNESS <u>[Signature]</u>	
76. SIGNATURE OF WITNESS <u>[Signature]</u>		77. SIGNATURE OF WITNESS <u>[Signature]</u>		78. SIGNATURE OF WITNESS <u>[Signature]</u>	
79. SIGNATURE OF WITNESS <u>[Signature]</u>		80. SIGNATURE OF WITNESS <u>[Signature]</u>		81. SIGNATURE OF WITNESS <u>[Signature]</u>	
82. SIGNATURE OF WITNESS <u>[Signature]</u>		83. SIGNATURE OF WITNESS <u>[Signature]</u>		84. SIGNATURE OF WITNESS <u>[Signature]</u>	
85. SIGNATURE OF WITNESS <u>[Signature]</u>		86. SIGNATURE OF WITNESS <u>[Signature]</u>		87. SIGNATURE OF WITNESS <u>[Signature]</u>	
88. SIGNATURE OF WITNESS <u>[Signature]</u>		89. SIGNATURE OF WITNESS <u>[Signature]</u>		90. SIGNATURE OF WITNESS <u>[Signature]</u>	
91. SIGNATURE OF WITNESS <u>[Signature]</u>		92. SIGNATURE OF WITNESS <u>[Signature]</u>		93. SIGNATURE OF WITNESS <u>[Signature]</u>	
94. SIGNATURE OF WITNESS <u>[Signature]</u>		95. SIGNATURE OF WITNESS <u>[Signature]</u>		96. SIGNATURE OF WITNESS <u>[Signature]</u>	
97. SIGNATURE OF WITNESS <u>[Signature]</u>		98. SIGNATURE OF WITNESS <u>[Signature]</u>		99. SIGNATURE OF WITNESS <u>[Signature]</u>	
100. SIGNATURE OF WITNESS <u>[Signature]</u>		101. SIGNATURE OF WITNESS <u>[Signature]</u>		102. SIGNATURE OF WITNESS <u>[Signature]</u>	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 2/57

5955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05943

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 2 1/2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 47x-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bank of Potomac River				d. STREET ADDRESS 1135 New Hampshire Ave., N.W.			
3. NAME OF DECEASED (Type or print) First ROBERT Middle MASON Last STAPLES				4. DATE OF DEATH Month May Day 21st, Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2nd, 1904	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck Hand				10b. KIND OF BUSINESS OR INDUSTRY Smoot Sand & Gravel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ernest Staples				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None 577-22-4641		17. INFORMANT Address Mrs. Doris Dahlstrom, 2431--E--St.N.W., Wash.DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined. This body was in such a poor state of preservation that cause could not be definitely determined. 795.5 DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED May 22nd, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23rd, 1959		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland Rd., Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24c. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

2

10-003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5038

STATE  
DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15, 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCASION OF DEATH <i>Heart Attack</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. Smith</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

103  
104  
105  
106  
107  
108  
109  
110  
111  
112  
113  
114  
115  
116  
117  
118  
119  
120  
121  
122  
123  
124  
125  
126  
127  
128  
129  
130  
131  
132  
133  
134  
135  
136  
137  
138  
139  
140  
141  
142  
143  
144  
145  
146  
147  
148  
149  
150  
151  
152  
153  
154  
155  
156  
157  
158  
159  
160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189  
190  
191  
192  
193  
194  
195  
196  
197  
198  
199  
200

1  
FOR STATE  
HEALTH DEPT.

5918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Capitol Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>621--60th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>COLLEEN</b> Middle <b>CATHERINE</b> Last <b>STRINE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22nd</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21st, 1954</b>		9. AGE (In years last birthday) <b>4</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None--Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Bethesda, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul F. Strine</b>				14. MOTHER'S MAIDEN NAME <b>Colleen C. Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Colleen C. Strine, 621--60th Ave. Capitol Hgts, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage &amp; Shbck</b> <b>812x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Comminuted fracture of skull</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by automobile</b>					
20c. TIME OF INJURY Hour <b>4:00</b> Min. <b>20</b> p. m. <b>5/17</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Capitol Hgts, Pr. Geo. Co. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 23rd, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.</b>		22d. LOCATION (City, town, or county) (State) <b>Ft Myer Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1919

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1919

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.



## 5956 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Hill</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4300--Branch Ave S.E.</b>				e. STREET ADDRESS <b>4300--Branch Ave. S.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>JESSE</b> Last <b>SWANN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5th</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 13th, 1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Richard T. Swann</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Brooks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Effie M. Swann 4300--Branch Ave., S.E.</b>			
17. INFORMANT <b>Effie M. Swann</b>				Address <b>4300--Branch Ave., S.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>11-30</b> , 19 <b>57</b> , to <b>May 5</b> , 19 <b>59</b> that I last saw the deceased alive on <b>May 1-</b> , 19 <b>59</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>A. Schwartzman</b> M.D. <b>2007 Nichols ave SE, Wash DC</b> PHYSICIAN'S NAME (Type) <b>A. Schwartzman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>5-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas</b>		22d. LOCATION (City, town, or county) _____ (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>				ADDRESS <b>1661--Gard Hope Rd., SE Wash. 20 DC</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

1-19-1908

FOR STATE  
HEALTH DEPT.

5919

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>9809 Lanham severn Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Iris</b> Middle <b>Tanner</b> Last <b>Tanner</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-30-19</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William McGill</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Clarke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b></b>			
17. INFORMANT <b>Roland Dennis Tanner; same address as # 2.</b>				Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ventricular fibrillation</b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital heart disease; interatrial septal defect.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>May 17, 1959</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch s Sons</b> ADDRESS <b>Hyattsville, Maryland.</b>				24a. REC'D BY REGISTRAR <b>MAY 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3019 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
Name of deceased: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Date of birth: [illegible]  
Place of birth: [illegible]  
Usual residence: [illegible]  
Cause of death: [illegible]  
Manner of death: [illegible]  
Signature of medical examiner: [illegible]  
Date: [illegible]

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05947

5920

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ardmore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>9110 Hobart St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy "B" Taylor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 May 1959</b>	
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Edward Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Joyce Kruger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>5/15/1959</b> to <b>5/15/1959</b> , that I last saw the deceased alive on <b>5/15/1959</b> , and that death occurred at <b>3:10A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Fred. Musser., M.D.</b>				ADDRESS (Street, city or town, state) <b>4410 74th Ave, Landover Hills, Md.</b>			
DATE SIGNED <b>5/16/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>				ADDRESS <b>Administrator.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05948										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum-Hyattsville			c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Heights-Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ager and Riggs Road					d. STREET ADDRESS 6610 Riggs Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Anthony George Vanagas					4. DATE OF DEATH Month Day Year May 12, 19 59					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-10		9. AGE (In years last birthday) 49 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plate printer		10b. KIND OF BUSINESS OR INDUSTRY Bu. of Ingraving		11. BIRTHPLACE (State or foreign country) Lithuania			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ignatius Vanagas					14. MOTHER'S MAIDEN NAME Magdalene					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT George F. Vanagas		7400 18th Ave., Hyattsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema and pulmonary edema 431 X DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Idiopathic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Va.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED May 13, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.				
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					4739 Baltimore Avenue Hyattsville, Maryland		24a. REC'D BY REGISTRAR MAY 15 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2202 Cherry Ave  
Cherry, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5958

## CERTIFICATE OF DEATH

05949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"At home"</u>		d. STREET ADDRESS <u>14625 R. St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>August J</u> Middle <u>WAHL</u> Last <u>WAHL</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11-1889</u>
9. AGE (In years last birthday) <u>70 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wahl</u>		14. MOTHER'S MAIDEN NAME <u>Matilda M. A. Meier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-12-2457</u>	
17. INFORMANT <u>Robert T Wahl</u>		Address <u>7915 Hallock St. Suit 4 apt 204</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Kidney</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>180X</u> DUE TO (c) <u>Interval between onset and death unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>58</u> , to <u>MAY 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 7</u> , 19 <u>59</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry N. Carlton</u> M.D.		ADDRESS (Street, city or town, state) <u>940-25th Street, N.W.</u> DATE SIGNED <u>May 7, 1959</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-9-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Calmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co Wash 2 D.C.</u>		ADDRESS <u>300-4th St N.E.</u>	
24a. REC'D BY REGISTRAR <u>May 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTORS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05950

5921

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 1904 Amherst Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle West Last West				4. DATE OF DEATH Month May Day 21 Year 1959					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1876			
9. AGE (In years last birthday) 83 yrs.		10. AGE (In years last birthday) 83 yrs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME John E. Johnson				14. MOTHER'S MAIDEN NAME Grace Morgan					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mt. Rainier Frances Moore, Daughter, 3722 36th, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Aut by occlusal clasp fracture. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from May 12, 1959, to May 21, 1959, that I last saw the deceased alive on May 21, 1959, and that death occurred at M, from the causes and on the date stated above.									
ACTUAL SIGNATURE A. Deitz				DATE SIGNED 5/21/59					
PHYSICIAN'S NAME (Type) Aaron Deitz									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-23-59		22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or county) (State) Darnestown, Md			
23. FUNERAL DIRECTOR'S SIGNATURE John A. Matthiely				ADDRESS 318 N. 1st St.		24a. REC'D BY REGISTRAR DATE MAY 25 '59			
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanes					

00150

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1935-03-15		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Physician's Signature		Physician's Title		Physician's Address	
1980-05-10		10:00 AM		[Signature]		M.D.		123 Main St, Baltimore, Md.	
Burial or Disposition		Burial		Cremation		Other		Place of Disposition	
Buried		Cremated		Other		Place of Disposition		Cemetery	
Buried		Cremated		Other		Place of Disposition		Cemetery	

1. This certificate is to be filled out by the attending physician or the medical examiner. It is to be signed by the physician or the medical examiner and filed with the local health department. It is to be sent to the State Department of Health, Baltimore, Maryland, for filing and for the purpose of determining the cause of death and for the purpose of determining the manner of death.

2. The cause of death should be stated in as much detail as possible. It should be stated in terms of the disease or condition which caused the death. It should be stated in terms of the organ or system which was affected. It should be stated in terms of the nature of the injury or disease. It should be stated in terms of the result of the injury or disease.

3. The manner of death should be stated in as much detail as possible. It should be stated in terms of the nature of the injury or disease. It should be stated in terms of the result of the injury or disease. It should be stated in terms of the nature of the injury or disease. It should be stated in terms of the result of the injury or disease.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05951

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Marie White		4. DATE OF DEATH May 17 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/94
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Gottfried J Aebersold	
14. MOTHER'S MAIDEN NAME Anna ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Josph White Husband Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 343X Encephalo-myelitis, viral DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 _____ Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14 19 59 to 5/17 19 59, that I last saw the deceased alive on May 17 19 59, and that death occurred at 8:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Nonnan Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny ST DATE SIGNED 5/17/59	
PHYSICIAN'S NAME (Type) NONNAN DONAT COMEAU M.D.		22. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 5/20/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch s Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

12.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

5923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10a, Film G-243 5/28/59.c.

05954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4081 Minnisota Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Parker</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-19</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Parker Williams, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emma Holmes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louise Williams; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Laceration of femoral artery</b> (a), stating the underlying cause last. DUE TO (c) <b>Shotgun wound of leg</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Shot in leg by another person.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4.00 P.M. 5-16-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tavern</b>		20f. (City or town) (County) (State) <b>Cedar Heights Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 16, 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Triangle Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhine &amp; Co.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 19 59</b>	
ADDRESS <b>3015-12 STREET N.E. WASH. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH USE

Place of death

Home

Never

Place of death (General location)

1011 Madison Avenue

City

State

Age

Color

Sex

Marital status

Occupation

Date of death

Time of death

Cause of death (as given by physician)

Immediate cause of death

Underlying cause of death

Contributing cause of death

Signature of physician

Signature of medical examiner

Date of completion

Signature of medical examiner (handwritten)

Date of completion (handwritten)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5924 CERTIFICATE OF DEATH

05955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Wood</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/76</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>19</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Breezy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pearson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frederick L. Wood</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH <b>5-wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 18</b> , 19 <b>59</b> , to <b>May 25</b> , 1959, that I last saw the deceased alive on <b>May 25 1959</b> , 19 <b>59</b> , and that death occurred at <b>7 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James E. Sasser, M.D.</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro Md</b>			
PHYSICIAN'S NAME (Type) <b>James E. Sasser, M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transporation</b>		22b. DATE THEREOF <b>5/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Plymouth</b>		22d. LOCATION (City, town, or county) (State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

1954

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH



21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5959

CERTIFICATE OF DEATH

Reg. Dist. No. 05956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7204-Elmhurst Street				d. STREET ADDRESS 7204-Elmhurst St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Zuriob				4. DATE OF DEATH Month Day Year May 18-1 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12-1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Martiniak				14. MOTHER'S MAIDEN NAME Theodore Undeman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Anthony J. Zuriob Same as 22B			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Coronary Thrombosis (b) DUE TO Coronary Arteriosclerosis (c) DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 yrs. - 5 yrs. -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-2, 1954, to May 18, 1959, that I last saw the deceased alive on May 17, 1959, and that death occurred at 6:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. D'Angelo M.D.				ADDRESS (Street, city or town, state) 4223 Silver Hill Rd Silver Hill, Md.		DATE SIGNED 5-18-59	
PHYSICIAN'S NAME (Type) John P. D'Angelo M.D.				Silver Hill, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5-22-59		St Joseph		Hazelton, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Mattingly Wash D.C.				ADDRESS 131-11288		24a. REC'D BY REGISTRAR DATE MAY 20 '59	
						24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

